NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the Register 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the Arizona Administrative Register after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. Sections Affected / Rulemaking Action

Sections Affected	Rulemaking Action
R9-22-101	Amend
R9-22-712	Amend
R9-22-715	Amend
R9-22-716	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-2903.01(H), (J), and (L), 36-2904(K, and 36-2908(C).

Implementing statute: A.R.S. § 36-2903.01(J) and 36-2904(K)

3. The effective date of the rules:

January 14, 1997

4. A list of all previous notices appearing in the Register addressing the final rule:

2 A.A.R. 3044, May 31, 1996 (Notice of Docket Opening)

2 A.A.R. 3976, September 13, 1996 (Notice of Amended Docket Opening)

2 A.A.R. 4220, October 11, 1996 (Notice of Proposed Rulemaking)

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson

Address: AHCCCS, Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop 4200
Phoenix, Arizona 85034

Telephone: (602) 417-4198

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6. An explanation of the rule, including the agency's reasons for initiating the rule:

Article 1: R9-22-101 adds and clarifies definitions related to hospital reimbursement. Definitions are added for accommodation, ancillary, AHCCCS inpatient hospital day(s) of care, ancillary department, billed charges, capital costs, continuous stay, cost-to-charge ratio, covered charges, encounter, ICU, Medicare crossover, medical education costs, medical review, NICU, outpatient hospital service, ownership change, prospective rate year, same day admit/discharge, and total inpatient hospital days. The definitions of the Data Resource Index, hospital, new hospital, operating cost, outlier, peer group, prospective rates, rebasing, tier, and tiered per diem are revised to improve their specificity. The definition of routine services was deleted. The Article 1 definitions are renumbered to reflect the additional terms.

Article 7: R9-22-712 is substantially revised to provide a more detailed description of inpatient and outpatient hospital rate-setting methods and payment practices. It should be noted that, with the exception of the two new subsections on rebasing and direct medical education, the revisions provide clarification of the process used to calculate hospital rates effective March 1, 1993, and to calculate subsequent updates. This additional clarity is proposed in response to litigation filed against the Administration.

A new subsection is added which describes the data used in establishing reimbursement rates including both claim and encounter data and cost report data. New subsections are also added to describe the calculation of the statewide inpatient hospital cost-to-charge ratio used for payment of outliers, treatment of unassigned tiered per diem rates, tier assignment, the annual update of reimbursement rates, rates for new hospitals, rates in the event of an ownership change, rates for psychiatric and rehabilitation hospitals, and specialty facilities.

Two additional new subsections merit special attention: rebasing and direct medical education. Both subsections make substantive changes. The rebasing subsection implements the provisions of S.B. 1283 regarding the timeframe for rebasing. This subsection also describes the scope of rebasing and the changes to the tiered system that may occur. The direct medical education subsection provides the flexibility for the Administration to reimburse hospitals for medical education costs directly rather than through the tiered per diem rates system.

Several subsections of the rule are substantially revised to further clarify the computation of rates including: the operating component, capital component, medical education component, outliers, and outpatient hospital reimbursement.

Technical corrections only are made to subsections addressing discounts and penalties, access to records, review of claims, claims receipt, out-of-state hospital payments and prior period payments.

The revisions to R9-22-715 provide flexibility to hospital rate negotiations between contractors (health plans) and hospitals. Finally, R9-22-716 has been updated to reflect provisions of S.B. 1283 relating to transplants.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable.

8. **The summary of the economic, small business, and consumer impact:**

The impact of the proposed changes are minimal. The proposed rule package provides further clarification to the hospital service payment methodology currently provided in rule, statute, and Medicaid State Plan (which is submitted to and approved by the Federal Government). The revisions proposed in this package do not change the reimbursement rates or methodology for calculating hospital rates provided March 1, 1993, to present, but rather provide additional detail relating to the complex methodology used to set hospital service reimbursement rates. The proposed rule also includes 2 new Sections, providing flexibility for reimbursing direct medical education and for rebasing future rates.

The proposed rule packet will potentially benefit all persons directly affected by the rule (for example, AHCCCS, Arizona Department of Economic Security, hospitals, health plans, taxpayers). Besides providing further clarification to the complex methodology used to set rates, the proposed rule will potentially provide a benefit as the Agency resources currently spent on issues related to the interpretation of the current rules can be redirected to provide other program functions.

The proposed new language in R9-22-712 provides the opportunity for AHCCCS to recognize new medical education programs in existing hospitals prior to a rebase year. In addition, the new Section on medical education potentially allows AHCCCS to reimburse hospitals directly for Graduate Medical Education (GME) rather than including the payment in the tiered per diem. The current method includes GME in the tiered per diem and therefore in the capitation payments made by AHCCCS to health plans. This current method, however, does not provide a method to ensure that hospitals with GME programs receive the GME payments that are included in the health plan capitation rate. Also, the separation of GME from the tiered per diem rates and capitation rates removes any disadvantage (due to the higher costs and rates associated with the GME program) that hospitals with GME programs may have in contract rate negotiations with AHCCCS health plans.

The revisions to hospital rate negotiations (R9-22-715) provide flexibility to rate negotiations between health plans and hospitals.

The revisions to specialty hospital payments (R9-22-716) are revised to comply with S.B. 1283 regarding transplantation services. Both R9-22-715 and R9-22-716 have 0 to minimal impact on persons directly affected by the rule.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

The changes between the proposed rules and the final rules are minimal. This is primarily due to the fact that AHCCCS provided contracting hospitals and health plans with a "courtesy copy" of the draft rule packet prior to submitting the proposed rules with the Secretary of State. Contracting hospitals and health plans submitted written comments on the draft rules to AHCCCS, and many of these comments were incorporated into the proposed rule packet that was submitted to the Secretary of State.

The substantive differences between the proposed rule and final rule include:

Grammatical, verb tense, and punctuation changes throughout;

Revised wording "adjustment factor equal to 4%" to read "adjustment factor based on available national data and Arizona experience in adjustments to Medicare-reimbursable costs" (R9-22-712(A));

Removed words "or more" from outlier criteria language (R9-22-712 (A)(6)(a));

Inserted a reference to R9-22-716 (specialty contracts) (R9-22-712(A));

Revised revenue codes for the NICU tier in the hierarchy chart to include 175 and 174, as appropriate by DOS (R9-22-712 (J)); and

Removed reference to pilot program rules (R9-22-718) under hospital rate negotiations (R9-22-715). This reference may be added after the pilot program rules are final.

10. **A summary of the principal comments and the agency response to them:**

AHCCCS received approximately 100 comments on the proposed rule packet from four entities: the Arizona Hospital and Health Care Association (AHHA), Arizona Physician's IPA (APIPA), Phoenix Memorial Hospital (PMH), and Gammage & Burnham. The majority of these comments resulted in a revision to the rule language.

Approximately 23% of the comments were directed towards the definitions in R9-22-101. Of these, 95% resulted in language being revised, with the remainder requesting clarification.

Approximately 75% of the comments were directed towards the hospital payment rules in Section R9-22-712. Of these, 25% related to issues currently under litigation, 25% resulted in the language being revised, 30% requested clarification on various issues, 10% requested that medical education payments be pulled out of the per diem rates, and the remaining 10% requested policy/language changes that were not made. The remaining 2% of the comments related to language clarification in Section R9-22-715.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable.

12. Incorporations by reference and their location in the rules:
Not applicable.

13. Was this rule previously adopted as an emergency rule?
No.

14. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101 Definitions

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-712 Payments by the Administration for Hospital Services
R9-22-715 Hospital Rate Negotiations
R9-22-716 Specialty Contracts

ARTICLE 1. DEFINITIONS

R9-22-101. Definitions

~~The following words and phrases, in~~ In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Accommodation" means those bed and board services provided to a patient during a hospital stay and includes the cost of all staffing, supplies, and equipment. The accommodation is typically semi-private except when the member must be isolated for medical reasons. Other types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit where bed and board are provided. Accommodation does not include observation.

~~1.~~2. "Acute mental health services" means inpatient or outpatient health services provided to treat mental or emotional disorders, as necessary for crisis stabilization, evaluation and determination of future service needs.

~~2.~~3. "AFDC" means Aid to Families with Dependent Children under Title IV-A of the Social Security Act, as amended.

~~3.~~4. "Aggregate" means the combined amount of hospital payments for covered services provided within the service area. It also applies outside the service area.

~~4.~~5. "AHCCCS" means the Arizona Health Care Cost Containment System which is composed of the Administration, contractors, and other arrangements through which health care services are provided to eligible persons.

~~5.~~6. "AHCCCS disqualified dependent" means a dependent child residing in a household with an AHCCCS disqualified spouse.

~~6.~~7. "AHCCCS-disqualified spouse" means the spouse of an MI/MN or state emergency services applicant, who is ineligible for AHCCCS MI/MN or state emergency services benefits because the spouse's separate property, when combined with other resources owned by all household members, exceeds the allowable resource limit.

~~7.~~8. "AHCCCS hearing officer" means a person designated by the Director to preside over administrative hearings regarding eligibility appeals and grievances.

9. "AHCCCS inpatient hospital day(s) of care" means the period of time beginning with the day of admission and includes each day of an inpatient stay for an eligible person, including the day of death, but excluding the day of discharge, provided that all medical necessity and medical review requirements have been met.

~~8.~~10. "Air ambulance" means a helicopter or fixed wing aircraft licensed under the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1, as amended, to be used in the event of an emergency to transport eligible persons to obtain services.

~~9.~~11. "Ambulance" means any motor vehicle licensed pursuant to the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1, especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of eligible persons requiring ambulance services.

12. "Ancillary department" means the department of a hospital that provides ancillary services and outpatient services, which are defined in the Medicare Provider Reimbursement Manual.

~~10.~~13. "Appeal" means a review process initiated in accordance with Article 8.

~~11.~~14. "Appellant" means any person or entity directly affected by an adverse action, policy or decision who initiates an appeal process.

~~12.~~15. "Applicant" means a person who submits, or on whose behalf is submitted, a written, signed and dated application for AHCCCS eligibility, but not for whom an eligibility determination has not been completed.

~~13.~~16. "Application" means an official request for AHCCCS benefits made in accordance with Article 3.

~~14.~~17. "Assignment" means enrollment of an eligible person with a contractor by the AHCCCS Administration.

18. "Billed charges" means charges that a hospital includes on a claim for providing hospital services to an eligible person consistent with the rates and charges filed by the hospital with the Arizona Department of Health Services.
19. "Capital costs" means capital-related costs which are defined in the Medicare Provider Reimbursement Manual, Chapter 28, such as building and fixtures, and movable equipment.
~~15.~~20. "Capped fee-for-service" means the payment mechanism by which contractors, subcontractors and other providers of care are reimbursed upon submission of valid claims for specific AHCCCS covered services and equipment provided to eligible persons. Payments will be made in accordance with an upper, or capped, limit of payment as established by the Director.
~~16.~~21. "Case record" means the file and all documents contained therein which are used to establish eligibility.
~~17.~~22. "Casualty insurance" means liability insurance coverage related to injury due to accidents or negligence.
~~18.~~23. "Catastrophic coverage limitation" means the financial limit as determined by the Director, beyond which the contractor is not at risk to provide or make reimbursement for treatment of illness or injury to members which results from, or is greatly aggravated by, a catastrophic occurrence or disaster including, but not limited to, natural disaster or an act of war, declared or undeclared, which occurs subsequent to enrollment.
~~19.~~24. "Categorically eligible" means those persons who are eligible as defined by A.R.S. § 36-2901(4)(b) or who are receiving Medicaid coverage from another state or territory.
~~20.~~25. "Certification period" means the period of time for which a person is certified as eligible for AHCCCS benefits.
~~21.~~26. "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
27. "Continuous stay" means the period of time during which a member receives inpatient hospital services without interruption beginning with the day of admission and ending with the day of discharge or death of the member.
~~22.~~28. "Contract" means a written agreement entered into between a person, organization or other entities and the Administration to provide health care services to members under the provisions of A.R.S. Title 36, Chapter 29, and these rules.
~~23.~~29. "Contractor" means a person, organization or entity agreeing through a direct (prime) contracting relationship with the Administration to provide those goods and services specified by contract in conformance with the requirements of such contract and these rules.
~~24.~~30. "Contractor of record" means the organization or entity in which a member is enrolled for the provision of AHCCCS services.
~~25.~~31. "Copayment" means a monetary amount, specified by the Director, which the member pays directly to a contractor or provider at the time covered services are rendered.
32. "Cost-to-charge ratio" means a hospital's costs for providing covered services divided by the hospital's covered charges for the same services.
~~26.~~33. "County eligibility worker" means a county employee designated to conduct eligibility interviews and determinations for AHCCCS.
34. Covered charges" means billed charges that represent necessary, reasonable, and customary items of expense for AHCCCS-covered services that meet medical review criteria of the Administration or contractor.
~~27.~~35. "Covered services" means those health and medical services described in Article 2.
~~28.~~36. "Current residence" means the current dwelling place of the family household whether it be a house, mobile home, trailer, hogan, tent, or any shelter used as a dwelling.
~~29.~~37. "DRI inflation factor" means the Data Resources Inc., Health Care Financing Administration-type hospital input price index for prospective hospital reimbursement which is published by DRI/McGraw-Hill.
~~30.~~38. "Date of application" means the date on which the county eligibility office receives a completed and signed Part I of the AHCCCS application form or receives official notification from a provider of emergency services as specified in Article 3.
~~31.~~39. "Date of determination" means the date on which a decision of the applicant's eligibility or ineligibility as an indigent or medically needy person, as an eligible low-income child, or as a state emergency services person is communicated by the county to the applicant by a Notice of Action and, for eligible applicants, to the Administration as specified in R9-22-334.
~~32.~~40. "Day" means a calendar day unless otherwise specified in the text.
~~33.~~41. "Deemed date of application" means the 30th day following either the original date of application or a previously deemed date of application. A deemed date of application is established for an untimely application and, for an untimely application, the deemed date shall replace the original date of application in determining the household's assets and resources and determining the household's income.
~~34.~~42. "Dependent child" means an unborn child or unemancipated person who is under the age of 18 or is age 18 if a full-time student in a secondary school, or in a vocational, technical, or trade school that is directly linked to the high school for which the student is receiving credits to be applied toward graduation and who is reasonably expected to complete the program before reaching age 19.
~~35.~~43. "DES" means the Arizona Department of Economic Security.
~~36.~~44. "Determination" means the process by which an applicant is approved for coverage as an indigent or medically needy person, an eligible low-income child, or a state emergency services person. Determination includes the decision by the county of an applicant's eligibility or ineligibility, the communication, for eligible applicants, of the decision by the county to the AHCCCSA Notification Unit, and the communication of the decision by the county to the applicant by a Notice of Action.
~~37.~~45. "Diagnostic services" means those services provided for the purpose of determining the nature and cause of a condition, illness or injury.
~~38.~~46. "Disenrollment" means the discontinuance of a member's entitlement to receive covered services from a specific AHCCCS contractor, and the member's name being deleted from the approved list of members furnished by the Administration to the contractor.

~~39.~~47. "Disqualified household member" means a person who is ineligible for indigent, medically needy, eligible low-income child, or state emergency services coverage due to a refusal to cooperate with the Title XIX eligibility process as required by state law.

~~40.~~48. "Eligible assistance children" means those children defined by A.R.S. § 36-2905.03(B).

~~41.~~49. "Eligible low-income children" means those defined by A.R.S. § 36-2905.03(C) and (D).

~~42.~~50. "Emancipated minor" means a person under age 18 who is married or divorced or in military service, or the subject of a court order declaring the minor to be emancipated (also see "Expressed emancipated minor").

~~43.~~51. "Emergency ambulance service" means:

a. Emergency transportation by a licensed ambulance or air ambulance company or persons requiring emergency medical services.
b. Emergency medical services which are provided before, during or after such transportation by a certified ambulance operator or attendant.

~~44.~~52. "Emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part.

~~45.~~53. "Emergency medical services" means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part.

54. "Encounter" means a record, submitted by a contractor and processed by AHCCCS, of medically related services that are rendered by a provider registered with AHCCCS to a member who is enrolled with the contractor on the date of service, and for which the contractor incurs any financial liability.

~~46.~~55. "Enrollment" means the process by which a person who has been determined eligible becomes a member of a contractor's plan under AHCCCS, pursuant to the limitations specified in these rules.

~~47.~~56. "E.P.S.D.T. services" means early and periodic screening, diagnosis, and treatment services for eligible persons under 21 years of age. For the purpose of these rules, the following meanings shall apply:

a. "Early" means, in the case of a family already enrolled in AHCCCS, as early as possible in the child's life or, in other cases, as soon as a family's eligibility for AHCCCS has been established.
b. "Periodic" means at appropriate intervals established by the Administration for screening to assure that a condition, illness or injury is not incipient or present.
c. "Screening" means the use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who may have a condition, illness or injury and the identification of those in need of more definitive study. For the purposes of the AHCCCS program, screening and diagnosis are not synonymous.
d. "Diagnosis" means the determination of the nature or cause of a condition, illness or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests and X-rays.
e. "Treatment" means any type of health care or services recognized under the state Plan submitted pursuant to Title XIX of the Social Security Act to prevent or ameliorate a condition, illness or injury or prevent or correct abnormalities detected by screening or diagnostic procedures.

~~48.~~57. "Equity" means the full cash or market value of a resource minus valid liens or encumbrances.

~~49.~~58. "Expressed emancipated minor" means a child whose parent(s) has (have) signed a notarized affidavit indicating that the child is no longer under parental support and control, and that he (they) has (have) surrendered claim to state and federal tax dependency deductions provided that the child is not living with a specified relative acting as a legal or de facto guardian and a court has not ordered custody with another person or agency.

~~50.~~59. "Facility" means any premise owned, leased, used, or operated directly or indirectly by or for a contractor or its affiliates for purposes related to a contract; or maintained by a provider to provide services on behalf of a contractor.

~~51.~~60. "Factor" means an organization, collection agency, service bureau or individual who advances money to a provider for his accounts receivable which the provider has assigned, sold or otherwise transferred, including transfer through the use of a power of attorney, to the organization or individual. The organization or individual receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. For purposes of this paragraph, the term "factor" does not include business representatives, such as billing agents or accounting firms as described within these rules, or health care institutions.

~~52.~~61. "Fair consideration" means money, goods or services which can be valued in terms of money that was received in exchange for property or resources transferred, and that has a value equal to at least 80% of the property or resources transferred.

~~53.~~62. "Federal emergency services" means emergency medical services covered under 42 CFR 440.255, March 14, 1991, as described in herein and on file with the Office of the Secretary of State, to treat an emergency medical condition for a person who is determined eligible pursuant to 42 CFR 435.406(b) and (c), March 14, 1991, as described in herein and on file with the Office of the Secretary of State.

~~54.~~63. "Full cash value" means the current value on homes and other real properties as determined by the County Assessor's Office for the county in which the real property is located.

~~55.~~64. "Generic drug" means the chemical or generic name, as determined by the United States Adopted Names Council (U.S.A.N.C.) and accepted by the federal Food and Drug Administration (FDA), of those drug products having the same active ingredients as prescribed brand name drugs.

~~56.~~65. "Grievance" means a complaint arising from an adverse action, decision, or policy by a contractor, sub-

contractor, noncontracting provider, nonprovider, county, or the Administration, presented by a person or entity as specified by Article 8.

~~57.~~66. "Gross business receipts" means the total cash received from the business activity.

~~58.~~67. "Gross earnings from employment" means the total payment received by an employee from an employer in exchange for goods or services.

~~59.~~68. "Head of household" means the family household member who assumes the responsibility for providing AHCCCS eligibility information for the family household members in accordance with Article 3 of these rules.

~~60.~~69. "Hearing aid" means any wearable instrument or device designed for, or represented as aiding or compensating for impaired or defective human hearing, and any parts, attachments or accessories of such instrument or device.

~~61.~~70. "High-risk pregnancy" means a pregnancy in which the mother, fetus, or newborn is or will be at increased risk for morbidity or mortality before or after delivery.

~~62.~~71. "Hospital" means a health care institution that ~~which~~ is licensed as a hospital by the Department of Health Services under ~~pursuant to~~ A.R.S. Title 36, Chapter 4, Article 2, ~~as a hospital,~~ and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of ~~such~~ certification.

72. "ICU" means the intensive care unit of a hospital.

~~63.~~73. "Incapacitated person" means any person who is mentally or physically impaired to the extent that he is unable to make or communicate responsible decisions concerning his person.

~~64.~~74. "Income in kind" means any non-cash item or service received by an individual from a person or organization.

~~65.~~75. "Indigent" means persons meeting income and resource criteria pursuant to A.R.S. § 11-297.

~~66.~~76. "Inmate of a public institution" means a person defined by 42 CFR 435.1009, May 20, 1991, as described in herein and on file with the Office of the Secretary of State.

~~67.~~77. "Interim change" means either a change occurring after the date of application and before the eligibility decision or a change occurring during the certification period.

~~68.~~78. "Legal guardian, conservator, executor, or public fiduciary" means a person appointed by a court or other protective order to be in charge of the affairs of a minor or incapacitated person.

~~69.~~79. "Legend drugs" means those drugs which under federal or state law or regulations may be dispensed only by prescription.

~~70.~~80. "Liquid assets" means all property and resources readily convertible to cash excluding a house or vehicle owned by a family household member.

81. "Medicare crossover" means a claim for services covered by Medicare for an eligible person with Medicare coverage.

82. "Medical education costs" means direct hospital costs for intern and resident salaries, fringes, and program costs, nursing school education, and paramedical education, which is defined in the Medicare Provider Reimbursement Manual, Chapter 28.

~~71.~~83. "Medical equipment" means durable items and appliances that can withstand repeated use, are designed primarily to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness or injury. This definition includes, but is not limited to, such items as bedpans, hospital beds, wheelchairs, crutches, trapeze bars and oxygen equipment.

~~72.~~84. "Medical record" means a single, complete record kept at the site of the eligible person's primary care physician which documents the medical services received by the eligible person, including inpatient discharge summary, outpatient and emergency care.

85. "Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to eligible persons are medically necessary and are covered services and that required authorizations are obtained by the provider before and while the service is rendered. The criteria for medical review are established by the Administration or contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

~~73.~~86. "Medical services" means services pertaining to medical care that are performed at the direction of a physician, on behalf of eligible persons by physicians, dentists, nurses or other health related professional and technical personnel.

~~74.~~87. "Medical supplies" means consumable items which are designed specifically to meet a medical purpose.

~~75.~~88. "Medically necessary" means those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law to:

a. Prevent disease, disability and other adverse health conditions or their progression, or
b. Prolong life.

~~76.~~89. "Medically necessary dentures" means partial or full dentures and services that are determined to be the primary treatment of choice or an essential part of an overall treatment plan designed to alleviate a medical condition as determined by the primary care provider in consultation with the provider dentist.

~~77.~~90. "Medically necessary sterilization" means sterilization to:

a. Prevent progression of disease, disability or adverse health conditions;
b. Prolong life and promote physical health. Sterilization for family planning is not included.

~~78.~~91. "Minor" means an unemancipated person who is under age 18.

~~79.~~92. "New hospital" means any hospital for which ~~cost report~~ Medicare Cost Report data and ~~claims~~ claim and encounter data are ~~were~~ not available for hospital rate development from any owner or operator of the hospital, ~~either~~ during either the initial prospective rate ~~setting~~ year or ~~for~~ rebasing.

93. "NICU" means the neonatal intensive care unit of a hospital that has been classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

~~80.~~94. "Noncontracting provider" means a provider who has a contract or subcontract with the system and renders covered services to an eligible person for whom such provider bears no contractual obligation.

~~81.~~95. "Nursing facility (NF)" means an institution (or distinct part of an institution) defined by Section 1919(a) of the Social Security Act, October 1, 1990, as described in herein and on file with the Office of the Secretary of State.

~~82.~~96. "Open enrollment" means a period of time during which all currently enrolled members may select membership with another AHCCCS contractor when such choice is available.

~~83.~~97. "Operating costs" means allowable accommodation and ancillary department hospital costs excluding capital and medical education costs.

~~84.~~98. "Outlier" means a hospital claim or ~~claims~~ encounter in which the AHCCCS inpatient hospital days of care have operating ~~cost~~ costs per day that meet the criteria described in R9-22-712(A)(6). ~~excluding capital and medical education, is in excess of the greater of:~~

~~a. The weighted average operating cost per day within a tier plus or minus three standard deviations.~~

~~b. The overall weighted average operating cost per day plus or minus two standard deviations across all tiers.~~

~~85.~~99. "Outpatient health services" means those preventive, diagnostic, rehabilitative or palliative items or services which are ordinarily provided in hospitals, clinics, physicians' offices and rural clinics, by licensed health care providers by, or under the direction of a physician or practitioner, to an outpatient.

100. "Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.

101. "Ownership change" means a change in a hospital's owner, lessor, or operator which is defined in 42 CFR 489.18(A).

~~86.~~102. "Palliative services" means those services required to reduce the severity or relieve the symptoms of a condition, illness or injury.

~~87.~~103. "Peer group" means ~~those~~ hospitals that ~~which~~ share a common, stable, and independently definable characteristic or feature which significantly influences the cost of providing hospital services.

~~88.~~104. "Pharmaceutical services" means medically necessary drugs prescribed by a primary care physician, a practitioner, or other physician or dentist upon referral by a primary care physician and dispensed in accordance with these rules.

~~89.~~105. "Pharmacist" means a person licensed as a pharmacist under A.R.S. Title 32, Chapter 18.

~~90.~~106. "Pharmacy" means an establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist and which is registered pursuant to A.R.S. Title 32, Chapter 18.

~~91.~~107. "Physicians' Current Procedural Terminology" (CPT) means the manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language that will accurately designate medical, surgical and diagnostic services.

~~92.~~108. "Physician services" means services provided within the scope of practice of medicine or osteopathy as defined by state law or by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.

~~93.~~109. "Practitioner" means physicians' assistants and registered nurse practitioners who are certified and practicing in an appropriate affiliation with a primary care physician as authorized by law.

~~94.~~110. "Prepayment" means an arrangement in which a contractor agrees to provide health care services for a prospective, predetermined, periodic, fixed subscription premium.

~~95.~~111. "Prescription" means an order to a provider for covered services, which is signed or transmitted by a provider authorized to prescribe or order such services.

~~96.~~112. "Preventive health care" means those health care activities aimed at protection against, and early detection and minimization of, disease or disability.

~~97.~~113. "Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes in advance the delivery of covered services contingent on their medical necessity.

~~98.~~114. "Prospective rates" means ~~those~~ inpatient or outpatient hospital rates defined in advance of a ~~the~~ payment period and representing full payment for covered services ~~in full~~ excluding any quick-pay discounts, slow-pay penalties, non-categorical discounts, and third-party payments regardless of billed charges or individual hospital costs.

115. "Prospective rate year" means the period from October 1 of each year to September 30 of the following year, except for the initial prospective rate year which is between March 1, 1993, and September 30, 1994.

~~99.~~116. "Public assistance" means benefits provided to a person either directly or indirectly by a city, county, federal or state governmental agency based on financial needs.

~~100.~~117. "Quality management" means a methodology used by professional health personnel that assesses the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

~~101.~~118. "Radiological services" means professional and technical X-ray and radioisotope services ordered by a physician or other licensed health professional for diagnosis, prevention, treatment or assessment of a medical condition. Radiological services include portable x-ray, radioisotope, medical imaging and radiation oncology.

~~102.~~119. "Rebasing" means the process by which ~~whereby~~ new Medicare Cost Report data and AHCCCS claim and encounter data are collected and analyzed to reset periodically ~~reset~~ the inpatient hospital tiered per diem rates or the outpatient hospital cost-to-charge ratios.

~~103.~~120. "Referral" means the process whereby an eligible person is directed by a primary care physician to another appropriate provider or resource for diagnosis or treatment.

~~104.~~121. "Redetermination" means the process by which an AHCCCS member re-applies for a new eligibility certification period prior to the expiration of the current certification period.

~~105.~~122. "Refusal to cooperate" means that a person has refused to be interviewed by or has failed to provide information or available verification to county or DES eligibility staff or an eligibility quality control reviewer, or has refused to sign the Intent to Cooperate Form, or has failed to keep a scheduled appointment without providing a reasonable explanation or has voluntarily withdrawn from the application for federal benefits when such an application is required by state law.

~~106.~~123. "Rehabilitation services" means physical and respiratory therapy, audiology services, and other restorative services and items, excluding outpatient speech and occupational therapy and hearing aids for eligible persons 21

years and older, required to reduce physical disability and restore the eligible person to an optimal functional level.

~~107.~~124. "Residual services" means all services not covered by AHCCCS that were available to county eligible individuals through county indigent medical care programs on January 1, 1981.

~~108.~~125. "Retroactive coverage for medically needy, medically indigent, eligible low-income children, or state emergency services persons" means the two-day period prior to the date of determination during which AHCCCS is responsible for payment of emergency services which are not used to meet the household's spenddown liability.

~~109. "Routine services" means those services and items included in an inpatient provider's daily room and board charge.~~

126. "Same day admit/discharge (SDAD)" means a hospital stay with the admit and discharge occurring on the same calendar day.

~~110.~~127. "Scope of services" means those covered, limited and excluded services set forth in Article 2 of these rules.

~~111.~~128. "Separate property" means real and personal property of a spouse, owned by such spouse before the marriage, or acquired by gift, devise or descent after the marriage.

~~112.~~129. "Service area" means the geographical area designated by the Administration within which a contractor shall provide, directly or through subcontract, covered health care services to members.

~~113.~~130. "Service location" means any location at which a member obtains any health care service provided by the contractor under the terms of a contract.

~~114.~~131. "Service site" means the location designated by the contractor at which members shall receive services from a primary care physician.

~~115.~~132. "Sick newborn" means an infant who is hospitalized from the date of birth and who meets one or more of the following:

a. Had a birth weight less than 1500 grams; or
b. Has a deteriorating or unstabilized condition requiring admission within 72 hours of birth to a level III perinatal care center, as defined by the Arizona Perinatal Trust, Recommendations and Guidelines for Perinatal Care Centers in Arizona, 1987, as described in herein and on file with the Office of the Secretary of State; copies also are available at the central office of the AHCCCS Administration; or
c. Has respiratory distress syndrome requiring ventilator support; or
d. Has significant medical problems requiring care for more than 72 hours in a level II or level III perinatal care center, as defined by the Arizona Perinatal Trust, Recommendations and Guidelines for Perinatal Care Centers in Arizona, 1987, as described in herein and on file with the Office of the Secretary of State; copies also are available at the central office of the AHCCCS Administration.

~~116.~~133. "S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C, 1396a(a)(10)(A)(ii)(IX), July 1, 1988, as described in herein and on file with the Office of the Secretary of State.

~~117.~~134. "Specialist" means a Board eligible or certified physician who declares himself or herself as such and practices a specific medical specialty.

~~118.~~135. "Social Security Administration (SSA)" means an agency of the federal government responsible for administering certain titles of the Social Security Act, as amended.

~~119.~~136. "Specified relative" means a nonparent caretaker of a dependent child who is a grandmother, grandfather, sister, brother, stepmother, stepfather, aunt, uncle, first cousin, niece, nephew, or person of preceding generations. A specified relative must be 18 or over to apply on behalf of a dependent child, unless awarded custody by a court.

~~120.~~137. "Spend down" means the dollar value of incurred medical expenses that the family household must have in order to bring their net annual income within the eligibility income limit.

~~121.~~138. "Spouse" means the husband or wife of an AHCCCS applicant or household member, who has entered into a contract of marriage, recognized as valid by the state of Arizona.

~~122.~~139. "State emergency services" means emergency medical services to treat an emergency medical condition, which services are covered under R9-22-217 for a person who is determined eligible pursuant to A.R.S. § 36-2905.05.

~~123.~~140. "Subcontract" means an agreement entered into by a contractor with any of the following:

a. A provider of health care services who agrees to furnish covered services to members.
b. A marketing organization.
c. Any other organization or person who agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligations to the Administration under the terms of a contract.

~~124.~~141. "SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.

~~125.~~142. "Third party" means any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member.

~~126.~~143. "Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure or ~~and~~ revenue codes, peer group, or NICU classification level, or any combination of these items.

~~127.~~144. "Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which ~~a day falls~~ an AHCCCS inpatient hospital day of care is assigned.

~~128.~~145. "Third party liability" means the resources available from a person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or eligible person.

146. "Total inpatient hospital days" means the total number of days, including all hospital subprovider and nursery days from the Medicare Cost Report for all payors. Observation days and swing bed days are not included.

~~129.~~147. "Untimely application" means an MI/MN application for which the date of determination is later than the 30th day following the date of application or, if the head of the household has agreed in writing to an extension, later than the 60th day following the date of application. For MI/MN-S.O.B.R.A. dual applications, when the completed application has been submitted to DES within 30 days after the date of application but DES has not determined S.O.B.R.A. eligibility within 30 days after the date

of application, the application for those household members for whom S.O.B.R.A. eligibility is being determined is not an untimely application if the date of determination is not later than the tenth working day after a determination of S.O.B.R.A. eligibility has been made by DES or the 20th working day after the application was forwarded to DES, whichever is earlier.

~~130.~~148. "Utilization control" means the overall accountability program encompassing quality management and utilization review.

~~131.~~149. "Utilization review" means a methodology used by professional health personnel that assesses the medical indications, appropriateness and efficiency of care provided.

~~132.~~150. "Work-related expenses" means non-reimbursed expenses related to employment for travel, meals, lodging, uniforms, licenses for employment, union dues, tools, or material required for employment.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712. Payments by the Administration for Hospital Services

A. Inpatient hospital reimbursement. ~~Payment by the~~ The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after March 1, 1993, ~~shall be made~~ on a prospective reimbursement basis. The ~~Prospective~~ prospective rates shall represent payment in full, excluding quick-pay discounts, slow-pay penalties, noncategorical discounts, and third-party payments for both accommodation ~~routine~~ and ancillary department services. The rates shall include reimbursement for operating, capital, and medical education costs, as applicable. The Administration shall classify ~~Each~~ each AHCCCS inpatient hospital day of care ~~a hospital stay shall be classified~~ into 1 ~~one~~ of several ~~tier~~ tiers appropriate to the services rendered for payment purposes. ~~This~~ The rate for a particular tier is referred to as the tiered per diem rate of reimbursement. Until the time of rebasing, as described in this Section, the number of tiers is 7 and the maximum number of tiers payable per continuous stay is 2. Payment of outlier or transplant claims or payment to out-of-state hospitals, freestanding psychiatric hospitals, rehabilitation hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. To calculate the tiered per diem rates for the initial prospective year, the Administration shall use Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1990 and a database consisting of inpatient hospital claims and encounters for each hospital with beginning dates of service for the period November 1, 1990, through October 31, 1991.
   a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation for the initial prospective rate year, the Administration shall inflate all the costs to a common point in time as described in subsection (A)(2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than 1 hospital, the Administration shall allocate the costs to each of the respective hospitals. Hospitals shall submit information to assist the Administration in this allocation.
   b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed under A.R.S. §36-2903.01(J). The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude claims and encounters that fail these edits from the database. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the database, the following claims and encounters:
      i. Those missing information necessary for the rate calculation,
      ii. Medicare crossovers,
      iii. Those submitted by freestanding psychiatric hospitals, and
      iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.

~~1.~~2. Tier rate components. The Administration shall establish inpatient hospital ~~Components of~~ prospective tiered per diem ~~methodology~~ rates based on the sum of the following 3 components: operating, capital and medical education. ~~Hospitals shall receive payment representing reimbursement for operating, capital, and medical education costs as follows:~~ The rate for the operating component shall be a statewide rate for each tier except for the ICU tier which is based on peer groups. The rate for the medical education component shall be hospital-specific. The rate for the capital component shall be a blend of statewide and hospital-specific values based upon a sliding scale until October 1, 2002. The Administration shall not include the medical education component in the tiered per diem rates if direct medical education payments are made under subsection (A)(12). The Administration shall use the following methodologies to establish the rates for each of these components and to calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals.
   a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the rate for the operating component shall be computed as follows:
      i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with federal regulation, 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
      ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary department

charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1991, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs.

iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these items. For the ICU tier, claims and encounters shall be further assigned to the urban or rural peer group. The tier rate for NICU Level II shall be calculated as 75% of the NICU Level III tier rate. For claims and encounters assigned to more than 1 tier, ancillary department costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered per diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (A)(6).

~~i. Establishing reimbursement rates.~~

iv. Operating rate calculation. The ~~Rates~~ rate for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in subsection (A)(2)(a) within the tier by the total number of ~~days~~ AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier. ~~within the tier. This calculation shall be performed differently for statewide and peer group rates. When the rate is statewide, the calculation shall be based on all of the costs and all of the days within the state. When the rate is peer grouped, the calculation shall be performed separately, based on all of the costs and all of the days within each peer group.~~

~~ii. Updating rates. Between rebasing years, tiered per diem rates shall be annually inflated by the Data Resources Incorporated market basket index for prospective payment system hospitals and adjusted for changes in length of stay in accordance with A.R.S. § 36-2903.01(J)(2) and (3).~~

~~iii. New hospitals shall receive the tiered per diem rates as established in subparagraph (i).~~

b. Medical education component.

i. ~~Establishing reimbursement rates.~~ Calculation of medical education costs and component rate. ~~(1) Hospitals shall receive payment to compensate for costs associated with advanced medical education training programs. Payments shall be~~ The Administration shall calculate the rate for the medical education component of the tiered per diem rate ~~set~~ on a hospital-specific basis ~~based on the daily costs for~~ by identifying the total direct medical education costs listed on the hospital's Medicare Cost Report. The medical education costs identified for each hospital shall reflect the medical education costs incurred by all the payors for the hospital's services, including AHCCCS. The Administration shall reduce the medical education costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The Administration shall divide the hospital's reduced medical education costs by the hospital's total inpatient days for all patients to yield the rate for the medical education component of the tiered per diem rate. The Administration shall inflate the medical education component to a common point in time, December 31, 1991, using the DRI inflation factor. ~~to March 1, 1993, the midpoint of the initial prospective rate year, using the DRI inflation factor.~~

~~(2) Actual medical education~~

ii. Indexing medical education component to tiers. The Administration shall index the rate for the medical education ~~add-on payments shall be indexed~~ component for ~~to~~ each tier by the ~~a~~ relative ~~weight factor~~ weighting of that tier's operating component to the operating component of all tiers. The relative ~~weight~~ weighting factor ~~is~~ for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's medical education component is multiplied by the medical education component to determine the medical education component rate for the particular tier. ~~of the hospital's tier operating by the weighted average of all the tier operating rates for that hospital.~~

~~ii. Updating rates. Between years in which the reimbursement system is rebased, medical education add-on payments shall be inflated forward by the Data Resources Index.~~

iii. New ~~hospitals~~ medical education programs. ~~shall not receive medical education payments between rebasing years.~~ The tiered per diem rates for hospitals with new medical education programs that are not reflected on the Medicare Cost Reports used to establish rates under this Section shall not include a medical education component until the Medicare Cost Reports used in rebasing reflect the costs of the new medical education programs. New medical education programs may be recognized prior to

a rebase year at the discretion of the Director. If a hospital has an existing medical education program that is reflected in its Medicare Cost Report but has added a new medical education program that is not reflected, the hospital's tiered per diem rates shall include a rate for the medical education component that reflects only those medical education costs included in the Medicare Cost Report.

c. Capital component.

i. ~~Establishing reimbursement rates.~~ Structure of the capital component. ~~(1) Hospitals shall receive payment to compensate for capital costs associated with treating eligible persons. After a 10-year phase-in, the capital component shall be combined with the operating component.~~ During the ~~phase-in~~ 10-year period beginning with the initial prospective rate year, the rate for the capital ~~reimbursement~~ component of the tiered per diem rate shall represent a blend of statewide and individual hospital capital costs in accordance with A.R.S. § 36-2903.01(J)(9). After September 30, 2002, the Administration shall combine the rate for the capital component with the rate for the operating component to produce a single statewide rate for the combination of the capital and operating components.

ii. Calculation of statewide capital costs and statewide capital component rate. The capital costs associated with inpatient hospital care shall be calculated in a manner similar to that described for operating costs in subsection (A)(2)(a)(ii.). Because of the way costs are reported on the Medicare Cost Report, capital costs are derived by subtracting the costs determined when the ancillary department cost-to-charge ratios and the accommodation costs per day include only operating costs and medical education costs from the costs determined when the ancillary department cost-to-charge ratios and accommodation costs per day include capital costs as well as operating costs and medical education costs. The Administration shall inflate the resulting capital costs for each hospital to December 31, 1991, using the DRI inflation factor and shall reduce the capital costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The statewide per day rate for capital costs shall be calculated by dividing the resulting total capital costs for all hospitals by the total AHCCCS inpatient hospital days of care reflected in the claim and encounter database.

iii. Computation of hospital-specific capital costs and hospital-specific capital component rates. The Administration shall calculate the hospital-specific capital costs per day for each hospital by dividing the capital costs identified for each hospital in subsection (A)(2)(c)(ii), as adjusted by the audit factor and inflated to December 31, 1991, by the AHCCCS inpatient hospital days of care for that hospital reflected in the claim and encounter database.

iv. Blending of capital rates. The Administration shall set the rate for the capital component by blending of the statewide and hospital-specific capital rates in accordance with the following schedule:

PROSPECTIVE RATE YEAR	HOSPITAL SPECIFIC	STATE-WIDE
3/1/93-9/30/94	90%	10%
10/1/94-9/30/95	80%	20%
10/1/95-9/30/96	70%	30%
10/1/96-9/30/97	60%	40%
10/1/97-9/30/98	50%	50%
10/1/98-9/30/99	40%	60%
10/1/99-9/30/00	30%	70%
10/1/00-9/30/01	20%	80%
10/1/01-9/30/02	10%	90%
On and after-10/01/02	0%	100%

v. Because the rate for the capital component is a blend of the statewide and hospital-specific costs, the capital component shall not be further inflated to the mid-point of the initial prospective rate year.

~~(2) Actual~~

vi. Indexing capital component to tiers. The Administration shall index the rate for the capital ~~payments shall be indexed~~ component for ~~to~~ each tier by ~~a~~ the relative ~~weight~~ weighting ~~factor~~ of that tier's operating component to the operating component of all tiers. The relative ~~weight~~ weighting factor ~~is~~ for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's capital component is multiplied by the capital component to determine the capital component rate for the particular tier. ~~of the hospital's tier operating rates by the weighted average of all the tier operating rates for that hospital.~~

~~ii. Updating rates. During the 10-year phase-in period, and between years in which the reimbursement system is rebased, capital payment shall be updated as follows:~~

~~(1) The statewide portion of the capital payment shall be inflated by the Data Resources Index.~~

~~(2) The hospital-specific part of the payment shall be revised using updated capital costs from the hospital's Medicare Cost Report. The percentage change in capital costs per day shown on the Medicare Cost Report from one year to the next shall be applied to the hospital-specific portion of the capital payment.~~

~~iii. New hospitals. Capital reimbursement for new hospitals shall be equal to the average capital cost per day and indexed according to statewide relative weights per tier.~~

~~2. Stop-loss-stop-gain mechanism. Until September 30, 1996, a stop-loss-stop-gain mechanism defines a reimbursement floor and ceiling.~~

~~a. The Administration shall identify hospitals in which payment levels for particular tiers would reimburse below the floor established in A.R.S. § 36-2903.01(J)(1). Tiered per diem rates shall then be reset at the floor level provided that there are at least 25 cases for that hospital in the rate-setting database for the tier.~~

~~b. The Administration shall identify hospitals in which payment levels for particular tiers would reimburse above the ceiling established in A.R.S. § 36-2903.01(J)(1). Tiered per diem rates shall then be reset at the ceiling level provided that there are at least 25 cases for that hospital in the rate-setting database for the tier.~~

d. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, under subsection (A)(6). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (A)(1) and used to determine the initial tiered per diem rates. For each hospital, the covered accommodation days on the claims and encounters shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters shall be multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital shall be determined in the same way as described in subsection (A)(2)(a) but shall include costs for operating, capital, and medical education. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.

e. Unassigned tiered per diem rates. In the case of a hospital for which no tiered per diem rate is assigned to a tier, the Administration shall pay the statewide rate for the operating component of that tier if the hospital has qualifying claims and encounters subsequent to the base year. The rates for the capital and medical education components of a tiered per diem rate, if applicable, shall be re-weighted for a tier to which no tiered per diem rate is assigned as described in subsections (A)(2)(b) and (A)(2)(c).

3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure or revenue codes, peer group, or NICU classification level or a combination of these items.

a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection (J). Claims for inpatient hospital services must meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than 2 tiers, regardless of the number of interim claims that is submitted by the hospital. If a hospital changes its designation under Medicare from a rural to an urban hospital, or visa versa, the Administration shall continue to assign claims from that hospital to the rural ICU tiered per diem rate, or visa versa, until the tiered per diem rates are rebased.

b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital cost-to-charge ratio multiplied by ancillary department and accommodation charges.

c. Seven tiers. The following 7 tiers shall be in effect until the time of rebasing:

i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered per diem rate.

ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered per diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier, those with an NICU revenue code shall be paid at the NICU tiered per diem rate. Any remaining AHCCCS inpatient hospital day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered per diem rate.

iii. ICU. The ICU tier shall be identified by a revenue code. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier, those with an ICU revenue code shall be paid at the ICU tiered per diem rate. If there are any AHCCCS inpatient hospital days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.

iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.

v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a

psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.

vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.

vii. Routine. The routine tier shall be identified by particular revenue codes and shall include AHCCCS inpatient hospital days of care that are not otherwise classified into the proceeding tiers or paid in accordance with subsection (A)(11). The routine tier may split only with the ICU tier

4. Annual update. After the initial prospective rate year and between rebasing years, the Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. §36-2903.01(J)(2) and (J)(9) as follows:

a. Inflation factor. The rates for the operating and medical education components of the tiered per diem rate shall be inflated to the midpoint of the prospective rate year, using the DRI inflation factor.

b. Length of stay adjustment. The rate for the operating component of the tiered per diem rate shall be adjusted for any change in the statewide average length of stay for eligible persons. The change in length of stay shall be computed each year by comparing the average length of stay for each tier based on claims and encounters to the average length of stay for each tier calculated in the previous year. The operating component of the tiered per diem rates shall be adjusted by the percentage change in length of stay. If the length of stay increases for a tier, the rate for the operating component shall be adjusted downward. If the length of stay decreases for a tier, the rate for the operating component shall be adjusted upward. Except for the first annual update of the initial prospective rate year, the Administration shall use claims and encounters that are from the federal fiscal year period beginning 2 years before the prospective rate year that is being updated. For the annual update for the prospective rate year beginning October 1, 1996, the claims and encounters with beginning dates of service from October 1, 1994, to September 30, 1995 shall be used for making any length of stay adjustment. For the annual update of the initial prospective rate year, the Administration shall use claims and encounters with beginning dates of service from March 1, 1993, to September 30, 1993. The Administration shall subject the claim and encounter data to the same data edits described in subsection (A)(1)(b). Outliers shall be excluded as identified in subsection (A)(6)(a).

c. Capital component update. For the capital component of the tiered per diem rate, the Administration shall adjust the hospital-specific and statewide average blend described in subsection (A)(2)(c). The Administration shall adjust the hospital-specific part of the capital component by using the capital costs from the hospital's subsequent Medicare Cost Report. The Medicare Cost Report used for the first update is FY1991. The percentage change in the capital costs per day, as shown on the hospital's Medicare Cost Report from one year to the next, shall be applied to the hospital-specific part of the capital component. The Administration shall recalculate the statewide average part of the capital component based on the percentage change in hospital-specific capital costs. The percentage change shall be limited to the initial prospective rate year statewide capital costs increased by the DRI inflation factor. The Administration shall adjust the rate for the capital component of the tiered per diem downward, if after the update, the statewide average rate of the capital component as a percent of the statewide average total tiered per diem rate exceeds the percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year.

5. New Hospitals. The Administration shall calculate the tiered per diem rates for new hospitals differently than the tiered per diem rates for hospitals for which Medicare Cost Reports and claims and encounters were used to establish the tiered per diem rates for the initial prospective rate year or for a rebase year. The tiered per diem rates paid to a new hospital shall be the sum of the operating and capital components. The rate for the operating component for a new hospital shall be the same as the rate for the operating component established in subsection (A)(2)(a). The rate for the capital component for a new hospital shall equal the statewide average rate for the capital component as described in subsection (A)(2)(c)(ii) and shall vary by tier based on an index that represents the statewide relative weight of each tier's operating component to the operating component of all tiers. The tiered per diem rates for new hospitals shall not include a medical education component. The annual update shall be applied to a new hospital's rates for its operating and capital components, except hospital-specific capital costs shall not be considered as described in subsection (A)(2)(c)(iii)

~~3.~~6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the covered ~~allowable~~ charges on a claim by ~~times~~ the statewide inpatient hospital cost-to-charge ratio.

a. Outlier criteria. For the initial prospective rate year, the Administration shall set the statewide outlier cost threshold for each tier at the greater of 3 standard deviations from the statewide mean operating cost per day within the tier, or 2 standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are 2 tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted threshold for the 2 tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient

hospital days of care for that tier and dividing the product by the total tier days for that hospital.

b. Update. The Administration shall update the outlier cost thresholds and outlier charge thresholds for each hospital. The outlier cost thresholds are updated annually by recalculating the standard deviations based on the claims and encounters used for the length-of-stay adjustment described in subsection (A)(4)(b). The outlier charge thresholds are updated as defined in subsection (A)(6)(a). Claims and encounters exceeding the updated outlier cost thresholds will be excluded for purposes of calculating the change in length-of-stay. The Administration shall estimate the operating cost of claims and encounters based on the application of an inpatient hospital-specific operating cost-to-charge ratio.

4.7. Transplants. The Administration shall reimburse hospitals for an AHCCCS ~~acute care~~ inpatient stay in which a covered organ transplant is ~~was~~ performed ~~either~~ through the terms of a relevant contract agreement. ~~, or, in the absence of a contract, at the AHCCCS statewide inpatient cost-to-charge ratio multiplied by allowed charges (billed charges that represent covered services and are medically necessary).~~ Pursuant to R9-22-716, if the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.

8. Rebasing. The Administration shall rebase the tiered per diem rates by the prospective rate year beginning October 1, 1998. The rebasing process shall include the following:

a. Rebasing data. The Administration shall use a hospital's Medicare Cost Report for a fiscal year ending at least 2 years before the prospective rate year in which the rebase is to begin. For example, for the rebase year of October 1, 1998, the Medicare Cost Reports would be for hospital fiscal years ending in 1996, or earlier. The Administration shall follow the procedures described in subsection (A)(1)(a) for Medicare Cost Report data, except that costs shall be inflated to December 31 of the fiscal year applicable to the Medicare Cost Report year, and a new audit factor shall be derived by the Administration based on available national and Arizona data. To calculate the rebased tiered per diem rates, the Administration may use the ancillary department or line item cost-to-charge ratios from the Medicare Cost Report. In addition for each hospital, the Administration shall use a database consisting of inpatient hospital claims and, if appropriate, encounters with beginning dates of service covered by the hospital's respective Medicare Cost Report reporting period. Claims and encounters included in the database will be those available at the time of rebasing that pass the Administration's data quality, reasonableness, and integrity edits described in subsection (A)(1)(b). The Administration shall exclude or adjust the claims or encounters that do not meet the medical review criteria at R9-22-717 and R9-22-209(C).

b. Rebasing components. The rebased tiered per diem rates shall include rates for the following 2 components: operating and capital. The Medical education component shall be included unless direct medical education is reimbursed under subsection (A)(12). The Administration shall follow the methodology described in subsection (A)(2) to establish the rebased rates for each of the components. However, during the rebasing process the Administration shall re-examine the current tier structure and may adopt an alternative structure, hierarchy, or number of tiers if analyses conducted by the Administration indicate that an alternative(s) is appropriate. The Administration shall add cost containment features at the time of rebasing.

c. Rebasing peer groups for the operating component. To rebase the rate for the operating component of the tiered per diem rate, the Administration shall re-analyze whether the operating component shall be peer grouped according to such factors as geographical location or major teaching versus non-major teaching hospital.

d. Rebasing the capital component. The capital component of the tiered per diem rate shall be a blend of statewide and hospital-specific capital costs pursuant to subsection (A)(2)(c). The Administration shall adjust the rate for the capital component of the tiered per diem rate downward if after rebasing the statewide average rate for the capital component as a percent of the statewide average total tiered per diem rate exceeds:

i. The percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year; or

ii. The most recently available national average percentage of capital costs to total inpatient hospital costs.

iii. The adjustment to the rate for the capital component shall be based on the lesser of subsection (i) or (ii).

e. Rebasing outliers. Depending on the payment methodology adopted at the time of rebasing, the Administration may not include provisions for payment of outliers.

f. Psychiatric and rehabilitation hospitals. At the time of rebasing, the Administration shall re-examine the basis of payment for freestanding rehabilitation and psychiatric hospitals. If the decision is made to continue to reimburse these hospitals according to the methodology described in subsection (A)(10), the Administration shall exclude the claims and encounters from these hospitals that are not paid by the tiered per diem reimbursement system.

g. Data required. Beginning with fiscal years ending in 1996, hospitals shall file with the Administration all Medicaid-specific schedules of the Medicare Cost Report at the time the Medicare Cost Report is submitted to the Medicare Intermediary as required in A.R.S. § 36-125.04.

9. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered per diem rates upon an ownership change.

10. Psychiatric and rehabilitation hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Arizona Department of Health Services and shall pay freestanding rehabilitation hospitals the rate for the operating component of the routine tiered per diem rate plus the rates for the capital and medical education components as appropriate or an all-inclusive per diem rate that is negotiated by the Administration.

11. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. §36-2903.01(J)(1).
12. Direct medical education payments. Instead of including a direct medical education component in the tiered per diem rates, the Administration may reimburse hospitals directly for the hospital's costs associated with direct medical education. In this case, the Administration shall not continue to calculate direct medical education costs using the methodology described in subsection (A)(2)(b)(i), and shall not update direct medical education payments in accordance with subsection (A)(4).

B. Outpatient hospital reimbursement. ~~Payment by the~~ The Administration shall pay for covered outpatient ~~acute care~~ hospital services provided to eligible persons on and after March 1, 1993, ~~shall be made~~ at the AHCCCS ~~hospital-specific~~ outpatient hospital cost-to-charge ratio, multiplied by the ~~allowed~~ covered ~~claim~~ charges ~~billed charges that represent covered services and are medically necessary~~.

1. ~~Establishing reimbursement rates~~. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio ~~is computed for each hospital~~ on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each ~~on a hospital-specific basis~~ hospital. Outpatient operating and capital costs shall be included in the computation but outpatient ~~Medical~~ medical education costs ~~are excluded from the computation because both inpatient and outpatient medical education costs are reimbursed through~~ that are included in the inpatient medical education component shall be excluded. To calculate the outpatient hospital cost-to-charge ratio for the initial prospective rate year for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in subsections (A)(1)(a) and (A)(1)(b). The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters for outpatient hospital services. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
   b. Cost-to-charge limit. To comply with federal regulation, 42 CFR 447.325, the Administration may limit cost-to-charge ratios at 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse ~~New~~ new hospitals ~~shall be reimbursed~~ at the weighted ~~AHCCCS~~ statewide average outpatient hospital cost-to-charge ratio multiplied by covered ~~allowed~~ charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing. ~~(billed charges that represent covered services and are medically necessary.)~~
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in specialty facilities.
~~3.~~4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse ~~Hospitals~~ hospitals ~~shall not be reimbursed~~ for emergency room treatment, ~~or~~ observation hours, or other outpatient hospital services performed on an outpatient basis, as described in subsection (B), if the eligible person is admitted ~~on the same day~~ as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment. ~~The Administration shall pay only the appropriate inpatient per diem rate for an eligible person who is admitted through the emergency room.~~
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every 1 to 4 years using updated Medicare Cost Reports and claim and encounter data.

C. Discounts and penalties. ~~Payment by the~~ The Administration ~~for~~ shall subject all inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, ~~shall be subject~~ to quick-pay discounts and slow-pay penalties in accordance with ~~Laws 1993, Chapter 6, § 29; Laws 1992, Chapter 302, § 14, as amended by Laws 1993, Chapter 6, § 27;~~ Laws 1992, Ch. 302, §14, as amended by Laws 1993, 2nd S.S., Ch. 6, § 27; Laws 1995, 1st S.S., Ch. 5, § 6 and A.R.S. § 36-2903.01(J)(6).

D. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall not withhold access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or its designated representative in performance of the Administration's utilization control activities. Failure to cooperate may result in denial or non-payment of claims.

E. Prior authorization. Failure to obtain prior authorization required by R9-22-210 shall be cause for denial or nonpayment of claims.

F. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may ~~shall~~ subject all hospital claims, ~~to include~~ including ~~outlier~~ outliers ~~claims, are subject~~ to prepayment medical review, or ~~and~~ post-payment review or both by the Administration. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O) and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more ~~most~~ appropriate level of care, ~~such adjustment to~~ which

shall be effective on the date when the different level of care was medically appropriate.

G. Claim receipt. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new date stamps. Claims that are pending for additional supporting documentation from hospitals will receive new date stamps upon receipt of the additional documentation, except as provided under R9-22-717. Claims that pend for additional supporting documentation shall not be counted in the calculation of the quick-pay discounts and slow-pay penalties pursuant to R9-22-712 (C). For purposes of this subsection, the timeframes ~~Timeframes~~ for submitting ~~submittal of~~ claims and the definition of a clean claim are ~~for purposes of this subsection, shall be~~ consistent with A.R.S. § 36-2904.

H. Out-of-state hospital payments. ~~Payment by the~~ The Administration shall pay for covered hospital services provided to eligible persons by out-of-state hospitals ~~shall be made~~ at negotiated discounted rates, the ~~Arizona~~ statewide average inpatient or outpatient cost-to-charge ratio multiplied by covered ~~allowed~~ charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest.

I. Prior period payments. ~~Payments by the~~ The Administration shall pay for covered hospital services, provided to eligible persons with inpatient hospital admissions and outpatient hospital services ~~prior to~~ before March 1, 1993, ~~shall be made~~ pursuant to R9-22-706.

J. Hierarchy For Tier Assignment.

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx-643.xx, 644.2x-676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 175 for DOS before 10/1/95 AND the provider has a Level II or Level III NICU, or Revenue Code of 174 for DOS on, or after 10/1/95 AND the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx- 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 175 or 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

R9-22-715. Hospital Rate Negotiations

A. Effective for inpatient hospital admissions and outpatient hospital services on or after March 1, 1993, contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care based on the prospective tiered per diem amount or the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by allowed charges set forth in A.R.S. § 36-2903.01 and R9-22-712 or at the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712.

1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within 7 seven days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, to include all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or will produce greater dollar savings than what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712.

a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:
   i. ~~member~~ Member mix;
   ii. ~~admissions~~ Admissions by AHCCCS-specified tiers;
   iii. ~~average~~ Average length of stay by tier and pattern of admissions, excluding emergency admissions;
   iv. ~~outliers~~ Outliers; and
   v. Risk-sharing arrangements.
b. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications to these assumptions. ~~Failure to obtain Administration approval will limit the contractor to using the prospective systems set forth in A.R.S. § 36-2903.01 and R9-22-712.~~
c. When contractors adjust or modify their assumptions, the reason for the adjustment or modification shall be included, as well as the new assumptions. Any ~~changes~~ change in ~~assumptions are~~ assumption is subject to approval, denial, or mutually-agreed-to ~~modifications~~ modification by the Administration.
d. To determine whether ~~if~~ the negotiated rate agreement produced reimbursement levels that did not in the aggregate exceed what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712, contractors shall require their independent auditors to evaluate the reasonableness of their assumptions as part of the annual audit. The independent auditor's audit program shall be consistent with AHCCCS audit requirements and shall be prior approved by the Administration.
e. Negotiated inpatient or outpatient rate agreements with hospitals ~~where~~ with which a ~~contractors~~ contractor has ~~have~~ a related party interest are subject to additional related party disclosure and evaluation. These ~~Such~~ evaluations are in addition to the procedures described ~~above~~ in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors auditor, or, at the contractor's ~~its~~ option, additional evaluations may be performed by the Administration.
f. The Administration may subject a ~~the~~ contractor's independent auditor's report to any ~~such~~ examination or review necessary to ensure accuracy of any or all findings related to aggregate rate determinations.
g. The Administration shall use its standards, consistent with the Request for Proposals and R9-22-502, to determine ~~if the~~ whether a contractor's inpatient or outpatient hospital subcontracts will ~~would~~ limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit a the member's availability or accessibility of services.

B. The Administration may negotiate or contract with hospitals on behalf of contractors for discounted hospital rates~~.~~ and may require that the ~~Negotiated~~ negotiated discounted rates ~~may be required to~~ be included in contracts between contractors and hospitals.
C. The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and provider. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to providers.

R9-22-716. Specialty Contracts

The Director may at any time negotiate or contract on behalf of providers, noncontracting providers, and the Administration for specialized hospital and medical services~~. Such services may include~~ including, but ~~are~~ not limited to, neonatology, neurology, cardiology, and burn care. If the Director ~~has contracted~~ contracts for ~~such~~ specialized services, contractors of record may be required to include the ~~such~~ services within their delivery networks and make contractual modifications necessary to carry out this Section. Specialty contractors shall take precedence over all other contractual arrangements between contractors of record and their subcontractors. Specialty contractors may require interim payments to specialty contractors on behalf of contractors of record for contract services received by members. ~~Such~~ Interim payments to specialty contractors may be deducted from capitation payments, performance bonds, or other ~~like~~ monies for payment on behalf of contractors of record. ~~Effective for inpatient hospital admissions and outpatient hospital services that begin on or after March 1, 1993, should the Director not negotiate or contract on behalf of providers, noncontracting providers and the Administration for transplant services, contractors of record shall use the payment rate pursuant to R9-22-712(A)(4).~~ If the Administration and a hospital that performed a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG TERM CARE SYSTEM

PREAMBLE

1. Sections Affected — Rulemaking Action

Article 3	
R9-28-301	Repeal
R9-28-301	New Section
R9-28-302	New Section
R9-28-303	Repeal
R9-28-303	New Section

R9-28-304	New Section
R9-28-305	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2932(P)

Implementing statutes: A.R.S. §§ 36-559, 36-2901, 36-2931, 36-2932(Q), 36-2933(B), 36-2936, and 36-2958

3. The effective date of the rules:

January 14, 1997

4. **A list of all previous notices appearing in the Register addressing the final rule:**

1 A.A.R. 1119, July 21, 1995 (Notice of Emergency Rulemaking)
2 A.A.R. 654, January 12, 1996 (Notice of Proposed Rulemaking)
2 A.A.R. 805, January 26, 1996 (Notice of Emergency Rulemaking)
2 A.A.R. 973, February 16, 1996 (Notice of Public Hearing on Proposed Rulemaking)
2 A.A.R. 1641, May 3, 1996 (Notice of Rulemaking Docket Opening)
2 A.A.R. 3002, May 31, 1996 (Notice of Termination of Proposed Rulemaking)
2 A.A.R. 3004, May 31, 1996 (Notice of Proposed Rulemaking)
2 A.A.R. 3044, May 31, 1996 (Notice of Rulemaking Docket Opening)

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Cheri Tomlinson, Policy & Rules Administrator

Address: AHCCCS Administration, Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop #4200
Phoenix, Arizona 85034

Telephone Number: (602) 417-4198

Facsimile Number: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

The Administration is repealing R9-28-301 and R9-28-303 and has adopted R9-28-301, R9-28-302, R9-28-303, R9-28-304 and R9-28-305. The adopted rules will replace emergency rules and are necessary to comply with rule making provisions of A.R.S. § 41-1001 *et seq.* for the preadmission screening (PAS) process used by the Administration to determine medical eligibility for applicants, eligible persons and members for long-term care services provided through the Arizona Long-Term Care System (ALTCS) program.

AHCCCS has conducted preadmission screening for ALTCS applicants, eligible persons and members since the beginning of the ALTCS program in 1988. During this time, the PAS instrument and the PAS process have been utilized under the general authority of A.R.S. § 36-2936 and A.A.C. Title 9, Chapter 28, Article 3. A.R.S. § 36-2936 requires that the agency adopt rules to establish a uniform statewide PAS program to determine medical eligibility for the ALTCS program.

The current rules, R9-28-301 and R9-28-303, have been challenged by Community Legal Services and the Arizona Center for Law in the Public Interest in *Shea and Lacy et al. v Chen, et al.* (Maricopa County Superior Court, No. CV 93-18886), as not properly apprising applicants, eligible persons and members of the medical eligibility requirements for ALTCS. Plaintiffs are requesting that the agency adopt more detailed rules that include:

- Definition of terms used by PAS assessors, including scoring definitions;
- Elements that are scored as well as the weights given;
- Standards for making a determination that a physician review is required;
- Definition of what it means to require an institutional level of care; and
- Standards for when the PAS will be completed by a nurse or a social worker.

The Court granted Plaintiffs' motion for summary judgment, indicating that the agency's more detailed preadmission screening policies should be "rules" subject to the rulemaking requirements of the Arizona Administrative Procedure Act.

In May 1994, Judge Rapp signed the Court Order. The Order requires for a period of 90 days from the date of the Order, or until changes to Article 3 have been promulgated pursuant to the Administrative Procedure Act, that AHCCCS use the proposed rule adoptions attached to the Order to determine medical eligibility for ALTCS services.

The PAS is a prerequisite to continued federal funding of the ALTCS program. Overall, the adopted PAS rules reflect conformity with federal Title XIX (Medicaid) requirements and requirements to retain federal monies for the ALTCS program, as mandated by A.R.S. § 36-2932(Q), which serves over 20,000 Arizonans.

The absence of PAS rules would leave the agency with no ability to guide the persons making assessments of functional, medical, and nursing needs for institutional level of care, either for new applicants or for those current ALTCS members whose eligibility is required to be redetermined annually. The current PAS instrument determines the need for institutional level of care so that the

Administration is able to provide the necessary care to individuals in need of an institutional level of care. The agency is also able to satisfy the federal government's requirement for a PAS as a condition of the AHCCCS waiver.

Finally, a summary of each of the adopted rules follows:

R9-28-301. Definitions. The Administration has added definitions of terms which are specific to the medical eligibility determination process for the ALTCS program. These are terms which are not used elsewhere in the ALTCS rules. Those other general ALTCS words and phrases are defined in R9-28-101 and in statute, A.R.S. §§ 36-2931 (ALTCS) and 36-2901 (AHCCCS, acute care). It should be noted that the new rule definitions were requested by Plaintiffs in Shea and Lacy v. Chen.

R9-28-302. General Provisions. The Administration has significantly expanded on the rule of the same name proposed for repeal, the current R9-28-301. The new rule implements A.R.S. §§ 36-2933(B) and 36-2936, statutes which mandate preadmission screening to determine if applicants are eligible for ALTCS institutional level services. This rule lays the groundwork for the PAS process and sets forth procedural steps for utilization of specific PAS instruments described in the 2 following rule adoptions, R9-28-303 and R9-28-304.

R9-28-303. Preadmission Screening for Elderly and Physically Disabled Individuals. The Administration has implemented that portion of A.R.S. § 36-2936(A) which calls for a PAS "instrument that assesses the functional, medical, nursing and social needs of the applicants." The rule describes assessment categories, details the scoring calculations and indicates points available and weights. Usage of this PAS instrument specifically for the elderly and physically disabled (EPD) population dates to 1992, when it was determined that separate PAS instruments were needed for EPD applicants and applicants with developmental disabilities due to the unique nature of those 2 distinct populations.

R9-28-304. Preadmission Screening for Individuals with Developmental Disabilities. The Administration has also implemented A.R.S. § 36-2936(A), and does so for individuals with developmental disabilities in accordance with A.R.S. § 36-559. Similar to the preceding rule, this Section describes assessment categories, details the scoring calculations and indicates points available and weights. This rule reflects certain age-specific variables concerning risk of institutionalization, in line with differing developmental needs of children and other applicants over their lifetimes.

R9-28-305. Reassessments. The Administration revised the language contained in the current R9-28-303. R9-28-303 will be replaced and a New Section R9-28-305 will prescribe rules for reassessment. The new rule implements that portion of A.R.S. § 36-2936(B) which states that "the Administration shall establish guidelines for the periodic reassessment of each member". The rule Section sets for the standards for such reassessments and indicates timeframes for conducting them. In the latter instance, the new Section goes beyond the old rule to identify specific exceptions to the usual annual intervals.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable.

8. **The summary of the economic, small business, and consumer impact:**

The language in these rules clarifies the implementation of A.R.S. § 36-2936, which was adopted by the Administration to comply with federal requirements for Medicaid long-term care services, and to comply with the provisions of AHCCCS' agreement with the Health Care Financing Administration to operate under a section 1115 waiver. Therefore, any economic impact resulting from this rule language is more likely a product of statutory and federal compliance, than of revised rule language.

The economic impact of these provisions are minimal. All persons directly affected by these provisions receive a benefit because compliance with the federal requirements helps to assure Arizona that federal dollars will be provided for the ALTCS program. Without the federal dollars the ALTCS program would have to be funded entirely by the State. Some cost shifting could occur, as persons with DD who were previously served by AHCCCS are now served by the Department of Economic Security (DES), and vice versa. The denial rates for initial applicants using the revised PAS have remained constant with the denial rates for initials using the previous PAS. This suggests that the revised PAS process is not denying more persons, but that it is more reliably and consistently selecting those DD persons who require the level of care provided in a nursing facility or ICF-MR.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

Rulemaking had begun several months ago but, due to an administrative technicality, the process had to be terminated and begun again (see Notices in the May 31, 1996 edition of the A.A.R.). During that prior rulemaking action, numerous oral and written comments were received during the public comment period and public hearings (these are detailed in the Concise Explanatory Statement). In response to the comments, the following clarifying changes were made and have been incorporated into the rule text found in Item 14 of this notice:

Change 1. One commenter indicated that it was unclear if the PAS assessor was employed by a nursing facility or AHCCCS. The word "Administration" was added before the word "assessor" in R9-28-302(C) to clarify that the assessor that performs the PAS is an employee of the agency.

Change 2. Clarified the intent of R9-28-302(H) by revising proposed language, which read "... require care that can only be provided at the nursing facility or ICF-MR...", to more accurately read "...require the level of care that is provided at a nursing facility or ICF-MR...".

Change 3. Added the phrase "...and may be referred by the assessor for physician review." to the end of R9-28-305(B). This change clarifies that, similar to the process allowed for initial PAS assessments, during a reassessment of eligibility, assessors may request a physician review if PAS results indicate an individual is not eligible for ALTCS or the transitional program.

Change 4. In addition to the changes mentioned above, GRRC staff reviewed the adopted rules and recommended style changes and other revisions to conform with and adhere to the format required by the Secretary of State's rulemaking guidelines. The vast majority of these rule language changes have been incorporated into these adopted rules. The agency also reviewed the matrices in R9-28-304(D), since GRRC staff comments made it apparent the information they contained could be confusing, and clarified the matrices. In the emergency rules, the agency used similar formats for the matrices in R9-28-303(C) and R9-28-304(D) - each included columns on the right side that identified the range/scale of total points available. Since some of the questions in the PAS tool for individuals with developmental disabilities do not have a weight, (that is, the score does not need to be multiplied to arrive at a weighed score), these columns in the related matrices found in R9-28-304(D) were of little use since the notation "not applicable" was contained in all rows. For clarity, these columns in the R9-28-304(D) matrices have been deleted from the adopted rules.

Change 5. The Administration added language in R9-28-302(J) to read, "The physician shall review the PAS instrument and available medical records and use the person's professional judgment in determining whether the individual is at risk of institutionalization. At minimum the physician shall consider the following:

1. ADL dependence;
2. Continence;
3. Orientation;
4. Behavior;
5. Medical conditions; stability, prognosis;
6. Medical nursing treatments including skilled monitoring, medications, therapeutic regimens;
7. Supervision requirements;
8. Caregiver skill, training requirements; and
9. Other factors of significance to the individual case.

If the physician is unable to determine eligibility from the PAS instrument and available medical records, the physician may conduct a face-to-face review with the individual or contact others familiar with the individual's needs, including primary care physicians or other caregivers. If the reviewing physician recommends overturning the eligibility determination of the initial assessor, the physician shall state the reasons for that decision in the comments section of the instrument.

Change 6. Finally, when the above-described revisions to the adopted rules were being made, the agency took the opportunity to replace in rule language the term "developmentally disabled individuals" with the more generally accepted term "individuals with developmental disabilities" as appropriate, a suggestion made by advocates. This was done for consistency within Chapter 28 since this change is also being made in current proposed rulemaking involving most of the other Articles in the Chapter.

10. A summary of the principal comments and the agency response to them:

Rulemaking on these rules had begun earlier this year but, due to an administrative technicality, it had to be terminated and begun again (see Notices in the May 31, 1996, edition of the A.A.R.). During that prior rulemaking action, comments were received from interested parties, either orally at public hearings and/or in writing, regarding the proposed Arizona Long Term Care System (ALTCS) preadmission screening (PAS) rules. As described in item 9, above, the Agency has made some revisions to proposed rule language based on these comments. Overall the comments that were received can generally be grouped into the following 7 broad areas.

1) Affect on ALTCS Eligibility/Perceived Number of Persons Being Discontinued or Denied Enrollment into ALTCS. Commenters were concerned that the PAS tool would raise eligibility thresholds so less people would be determined eligible for ALTCS. The agency noted that the PAS is a tool to determine medical eligibility for the ALTCS program and was not revised to raise eligibility thresholds. Revisions to the tool were made to comply with the HCFA-approved AHCCCS waiver and to appropriately address the needs of EPD and developmentally disabled populations in determining their "at risk" status. This area of concern is further addressed in the Concise and Explanatory Statement.

2) Definitions, Clarity, and Understandability. The Administration will revise language in R9-28-302(C) to better clarify who employs the PAS assessor. Most of the remaining comments regarded specific definitions or why a term was defined differently for the 2 populations served by ALTCS: the elderly and physically disabled (EPD) and individuals with developmental disabilities. Agency responses discussed why different definitions are appropriate and necessary to distinguish between the unique characteristics of these 2 groups. For example, the definition of "dressing" varies for a 66 year old EPD member versus a 3 year old member with developmental disabilities, since the latter would probably always need assistance in selecting and putting on clothes.

There seems to be a misconception that the complexity or simplicity of an eligibility process inherently makes the process "good" or "bad", and that complex eligibility processes are not understandable. The Administration believes it is critical to have a tool that is statistically reliable and valid to identify appropriate populations to be eligible in an objective and consistent manner. Statistical tools incorporate such methods as bi-variate and multi-variate models which means that the process will be more complex. The Administration believes that any complexity in the revised PAS process is a by-product of its ability to more effectively and appropriately identify applicants who have characteristics which indicate a need for the level of

care provided in a nursing facility or ICF-MR. Complexity does not necessarily mean the process is not understandable. The rule language identifies the steps (for example, who is eligible, criteria that are scored) with which interested parties must be familiar in order to understand the requirements for eligibility. The rule language also identifies circumstances where the applicant's PAS score does not meet the threshold, and for which physician consultant review may be used to determine, if the applicant's unique functional abilities or medical conditions necessitate the level of care provided in a nursing facility or ICF-MR. This area of concern is further discussed in the Concise Explanatory Statement.

3) Transitional Program. The Administration received comments related to the ALTCS Transition Program. Responses indicated that this program is addressed in R9-28-306 which is not included in the proposed rules being reviewed at this time. However, after discussions with the various stakeholders, AHCCCS understands that the stakeholders would like to have the ALTCS Transitional Program expanded to include new applicants, rather than just members being reassessed. Expanding the Transitional Program would complement the ALTCS program, however, expansion of the Transitional Program requires legislative and/or Health Care Financing Administration (HCFA) approval. If AHCCCS wants federal funding for the program, HCFA approval would be required. In addition, HCFA has been clear that its approval of the Transitional Program was contingent upon the full implementation of the revised PAS process for the developmentally disabled population.

4) Statutory Authority. A commenter questioned the agency's authority to not complete a PAS assessment on a hospitalized person unless discharge is anticipated within 7 days. Under the AHCCCS waiver from the federal government, hospitalized individuals and others not requiring long term care are excluded from the optional institutionalized eligibility categories.

5) Standards for Physician Reviews. There were comments received concerning the referral of cases from PAS assessors to physicians for medical review, information used in making assessments and the degree to which clinical and professional standards should be specified in rule. To address some of these concerns AHCCCS will revise the proposed rule language in R9-28-305(B). Some commenters suggested that the specific standards used by physicians when reviewing PAS assessments be in rule. The Administration responded that it is impossible to specify clinical and professional judgment in rule since there will be times when individuals will present with unique combinations of medical needs and a physician will need to apply professional medical and clinical judgment. Specifying specific standards for this judgment in rule would be impossible as well as limiting and ultimately detrimental to the individual. This fact was recognized and acknowledged by the Attorney General's office when the emergency PAS rules were approved. The established guideline used by a physician in determining eligibility for the program is that the medical and functional needs of the individual place him or her at risk of institutionalization in a nursing facility or ICF-MR. To apply the statutory standard, the physician is using his or her medical judgment based on years of education and experience. The physician is required by rule (R9-28-302(J)) to document the basis for the final decision. The Administration clarified that at a minimum the physician shall consider certain categories of information listed in the rule to make a decision.

6) Not Related to the Scope of the Rules and Recommendations. There were comments received that did not relate specifically to the scope of the rules in question or were recommendations regarding issues that, again, did not relate to the proposed rules.

7) Scoring Methodology as it relates to Autism (all ages) and Mental Retardation (6-11 year olds). The majority of comments dealt with the validity of the PAS assessment tool and the scoring process. The agency responses described the significant effort that went into first developing age specific PAS tools and then pilot testing the process and affirmed the agency's belief in the validity and effectiveness of the tool. The final PAS tool represented over 2 years worth of field research, data analysis and testing on multiple populations.

The PAS for individuals with developmental disabilities was developed during a several year process involving representatives from AHCCCS, DES/DDD, the provider community and state and national experts on the MR/DD population. The overall approach is described in detail in the January, 1995, report, "Development of the Pre-Admission Screening for the Developmentally Disabled" and discussed further in the Concise Explanatory Statement. In summary, the following steps were taken:

- An expert advisory group consisting of AHCCCS, DES/DDD, and provider representatives was formed to evaluate the existing PAS and to make recommendations for its revision/replacement;
- The panel conducted an exhaustive literature search, reviewed other PAS instruments from around the country, and ultimately developed a framework for a new DD PAS that measures variables of importance to MR/DD individuals, while segmenting the population into 4 age cohorts;
- The panel produced 8 drafts of the PAS instrument, each time refining and improving the previous version;
- Draft 8 was used to conduct a pilot study, during which the data was collected from 500+ individuals, (current ALTCS as well as person denied or who had never applied due to expectation of denial), and analyzed to determine the best combination of variables to be used in measuring need within each age cohort. It is important to note that the PAS "pilot study" was actually several studies. After the initial pilot study was completed, and preliminary PAS instruments developed, the agency conducted a number of follow-up-tests to further refine and validate the instruments;
- Over 200 different combinations of variables, or "models" were tested across the 4 age cohorts, before the agency concluded it had found the best possible methodologies for predicting need for Title XIX services;
- After this "quantitative" analysis was complete, clinical staff from the agency examined case records in detail, to verify the reasonableness of the new PAS and to recommend refinements; and
- The PAS development process also was reviewed by a panel of national experts on developmental disabilities, who provided guidance on, and affirmation of, the agency's approach.

During the pilot study, AHCCCS evaluated all variables for all age cohorts, with the objective of finding the combination of variables within each age cohort that best predicted the need for Title XIX services. In performing this type of "targeted" analysis, the agency found that some variables were very strong predictors of need for one cohort, but less so for others. Usually, when this occurred, it was because some other sets of variables that measured the same functional characteristics were better able to predict need for the latter cohorts and so including the poorly performing variable would have been duplicative.

For example, a diagnosis of mental retardation (moderate, severe, or profound) was found to be a powerful predictor of need for Title XIX services among 12+ year-olds, but not among 6-11 year olds. Instead, the need for 6-11 year old scoring methodology includes communication and behavior variables not used for 12+ year olds, but which measure many of the same characteristics. While the agency could have elected to have a uniform set of variables for all individuals with developmental disabilities, this type of "one size fits all" approach would have resulted in a weaker PAS for each of the cohorts and would have produced denials for persons who are qualifying for the program today.

Despite the greater efficacy of having different scoring methodologies for different age cohorts, the agency was cognizant of the potential effect this could have on individuals "aging out" from one group to next. To determine how well the different methodologies "fit" together, the agency evaluated 11 year olds in the pilot study using both the 6-11 and the 12+ methodologies. The 2 methodologies produced identical eligibility results, supporting the notion that the 2 scoring approaches are sound even if based on a different combination of variables.

It should be noted that a recent in-depth review, HCFA's contracted evaluator of the AHCCCS program (Laguna Research Associates) concluded that the revised PAS is "....doing an excellent job of targeting eligibility to those at risk of institutionalization". Implementation of the revised PAS process provides assurance that persons requiring the level of care provided in a nursing facility/ICF-MR are eligible for the ALTCS program. (In fact, more children with developmental disability are eligible through the revised PAS process, and fewer children have to be referred for physician review through the revised PAS process.)

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
Section 1902(e)(9) of the Social Security Act (01-01-95) - R9-28-302(D).

PAS instrument for elderly and physically disabled individuals (10-92) - R9-28-303(B).

PAS instruments for individuals with developmental disabilities (8-95) - R9-28-304(C).

13. **Was this rule previously adopted as an emergency rule? If so, indicate the Register citation:**
1 A.A.R. 1119, July 21, 1995

2 A.A.R. 805, January 26, 1996

14. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 3. PREADMISSION SCREENING

Section
R9-28-301. ~~General provisions~~ Definitions
R9-28-302. General Provisions
R9-28-303. ~~Reassessment~~ Preadmission Screening for Elderly and Physically Disabled Individuals
R9-28-304. Preadmission Screening for Individuals with Developmental Disabilities
R9-28-305. Reassessments

ARTICLE 3. PREADMISSION SCREENING

R9-28-301. ~~General provisions~~ Definitions

~~A. To qualify for services under the ALTCS program, an individual shall meet the eligibility criteria as described in Article 4 of this Chapter and require long-term care services at an Intermediate or Skilled level of care as determined through preadmission screening.~~

~~B. Applicants for the ALTCS program shall be assessed using the preadmission screening instrument prescribed in this Section. The preadmission screening instrument shall be a standard form prescribed by the Director and used uniformly for the ALTCS program. The preadmission screening instrument shall consist of a standard set of questions and criteria designed to assess the functional, medical, psychosocial and nursing services needs of the individual.~~

~~C. When determining the medical eligibility of an ALTCS applicant on an original application for benefits and upon reassessment of eligibility, and the applicant exhibits indications of chronic mental illness, the following shall apply:~~

~~1. The determination of medical eligibility for those applicants who score above the preadmission screening eligibility threshold for ALTCS benefits shall be referred to a physician for the determination of medical eligibility.~~

~~2. The reviewing physician to whom the application is referred shall determine whether the applicant is medically eligible for ALTCS benefits based upon the medical care needs of the applicant other than those needs determined by the physician to be attributable to the chronic mental illness.~~

~~D. The preadmission screening instrument shall be used to:~~

~~1. determine the need for service in a Nursing Facility (NF) Class 1, 2, 3, and 4, or Intermediate Care Facility for the Mentally Retarded (ICF-MR);~~

~~2. assist in evaluation of appropriate and cost-effective placement for services;~~

~~3. assist in the assessment and determination of ventilator dependent individuals for inclusion in the special fee for service ventilator dependent program; and~~

~~4. assist in evaluation of the need for home and community based services.~~

~~E. In addition to a preadmission screening, to qualify for ALTCS institutional services an individual shall have certification documenting the individual's need for long-term care services. An individual's need for long-term care nursing facility services shall be certified and recertified in accordance with R9-28-511 by a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician.~~

A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and A.A.C. Title 9, Chapter 28, Article 1, for elderly and physically disabled individuals and for individuals with developmental disabilities:

1. "Acute" means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.
2. "Chronic" means a medical condition that is always present, occurs periodically, or is marked by a long duration.
3. "Constant/constantly" means at least once a day.
4. "Current" means belonging to the present time.
5. "Disruptive behavior" means inappropriate behavior that interferes with an individual's normal activities or the activities of others and requires intervention to stop or interrupt the behavior.
6. "Frequent/frequently" means weekly to every other day.
7. "Functional assessment" means an evaluation of information about an individual's ability to perform activities related to developmental milestones, activities of daily living, communication, and behaviors.
8. "History" means a medical condition that occurred in the past and may or may not have required treatment and is not now active.
9. "Intervention" means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends/family to control the behavior.
10. "Medical assessment" means an evaluation of an individual's medical condition and the individual's need for medical services.
11. "Medical/nursing services and treatments" means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition/diagnosis. Durable medical equipment and activities of daily living assistive devices are not considered to be treatment unless the equipment or devices are used specifically and actively to resolve the existing medical condition.
12. "Occasional/occasionally" means less than once per week.
13. "Physical participation" means active participation, not just being passive or cooperative.
14. "Physically lift" means actively bearing some part of an individual's weight during movement or activity and excludes bracing or guiding activity.
15. "Social worker" means an individual with a baccalaureate or master's degree in social work, rehabilitation, counseling, education, sociology, psychology, or other closely related field, or 2 years of case management related experience.
16. "Special diet" means a diet planned by a dietitian, nutritionist, or nurse such as high fiber, low sodium, or pureed.
17. "Toileting" means the process involved in managing the elimination of urine and feces in an appropriate place.
18. "Vision" means the ability to perceive objects with one's eyes.

B. Elderly and physically disabled. In addition to definitions contained in subsection (A), for elderly and physically disabled individuals only:

1. "Aggression" means physically attacking another, including, but not limited to, throwing objects, punching, biting, pushing, pinching, pulling hair, scratching, and physically threatening behavior.
2. "Bathing" means the process of washing, rinsing, and drying all parts of the body, including an individual's ability to transfer to a tub or shower and to obtain bath water and equipment.
3. "Continence" means the ability to control the discharge of body waste from bladder or bowel.
4. "Dressing" means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear, including weather appropriate articles but excluding aesthetic concerns such as matching colors. This includes artificial limbs, braces, and other appliances that are needed daily.
5. "Eating" means the process of putting food and fluids by any means into the digestive system.
6. "Elderly" means age 65 or older.
7. "Emotional and cognitive functioning" means an individual's orientation and mental state, as evidenced by overt behaviors.
8. "EPD" means elderly and physically disabled.
9. "Grooming" means the process of tending to one's appearance. This may include, but is not limited to, combing or brushing hair, washing face and hands, shaving, and performing routine nail care, oral hygiene (including denture care), and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, and applying make-up.
10. "Mobility" means the extent of an individual's purposeful movement within a residential environment.
11. "Orientation" means an individual's awareness of self in relation to person, place, and time.
12. "Physically disabled" means the inability to do any substantial gainful activity by reason of any medically determinable physical impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.
13. "Self-injurious behavior" means self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.
14. "Sensory" means of or relating to the senses.
15. "Suicidal behavior" means an act or intent to take one's life voluntarily.
16. "Transferring" means an individual's ability to move horizontally or vertically between 2 surfaces within a residential environment, excluding transfer for toileting or bathing.
17. "Wandering" means moving about with no rational purpose and with a tendency to go beyond physical parameters of the environment in a manner that may jeopardize safety.

C. Developmentally disabled. In addition to definitions contained in subsection (A), for only individuals with developmental disabilities:

1. "Aggression" means physically attacking another, including, but not limited to, throwing objects, punching, biting, pushing, pinching, pulling hair, and scratching.
2. "Ambulation" means the ability to walk and includes the quality of the walking and the degree of independence in walking.
3. "Associating time with events and actions" means an individual's ability to associate regular events with specific time frames.
4. "Bathing or showering" means an individual's ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.
5. "Caregiver training" means a direct care staff or caregiver trained in special health care procedures normally performed or monitored by a licensed professional, such as a registered nurse. These procedures may include, but are not limited to, ostomy care, positioning for medical necessity, use of adaptive devices, or respiratory services such as suctioning or small volume nebulizer treatments.
6. "Clarity of communication" means an ability to speak in a recognizable language or use a formal symbolic substitution, such as American-Sign Language.
7. "Climbing stairs or ramps" means an individual's ability to move up and down stairs or ramps.
8. "Crawling and standing" means an individual's ability to crawl and stand with or without support.
9. "Developmental milestone" means a measure of an individual's functional abilities including fine and gross motor skills, expressive and receptive language, social and self-help skills, and emotional/affective development.
10. "DD" means developmentally disabled.
11. "Dressing" means the ability to put on and remove articles of clothing and does not include braces nor does it reflect an individual's ability to match colors or choose clothing appropriate for the weather.
12. "Eating/drinking" means the process of putting food and fluid by any means into the digestive system.
13. "Expressive verbal communication" means an individual's ability to communicate thoughts with words or sounds.
14. "Food preparation" means the ability to prepare simple meals.
15. "Hand use" means the ability to use the hands, or hand if an individual has only one hand, or has the use of only one hand.
16. "Limited/occasional" means a small portion of an entire task or assistance required less than daily.
17. "Personal hygiene" means the process of tending to one's appearance. This may include, but is not limited to, combing or brushing hair, washing face and hands, shaving, and performing routine nail care, oral hygiene (including denture care), and menstrual care. Personal hygiene does not include aesthetics such as styling hair, skin care, and applying make-up.
18. "Physical interruption" means immediate hands-on interaction to stop a behavior.
19. "Remembering instructions and demonstrations" means an individual's ability to recall instructions or demonstrations on how to complete specific tasks.
20. "Resistiveness/rebelliousness" means any inappropriate, stubborn, or uncooperative behavior excluding difficulty with processing information or reasonable expression of self-advocacy.
21. "Rolling and sitting" means an individual's ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially designed chair.
22. "Running or wandering away" means to leave a situation or environment without either notifying or receiving permission from appropriate individuals as would normally be expected.
23. "Self-injurious behavior" means an individual's repeated behavior that causes injury to the individual and may include, but is not limited to, biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, and head slapping or banging.
24. "Verbal or physical threatening" means any behavior in which an individual uses words, sounds, or action to threaten harm to self, others, or objects.
25. "Wheelchair mobility" means an individual's mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

R9-28-302. General Provisions

A. To qualify for services described in A.R.S. § 36-2939 under the Arizona Long-term Care System (ALTCS), an individual shall meet the criteria described in Article 4 and shall be determined to require care at the level of a nursing facility or an intermediate care facility for the mentally retarded (ICF-MR) in accordance with the preadmission screening (PAS) process described in this Article.

B. An elderly or physically disabled (EPD) individual shall be assessed using the PAS instrument prescribed in R9-28-303 with the exception of physically disabled children less than 6 years of age who shall be assessed using the age-specific PAS instrument prescribed in R9-28-304 and then referred for physician review in accordance with R9-28-302(J). An individual with developmental disabilities shall be assessed using the PAS instrument prescribed in R9-28-304 with the exception of an individual with developmental disabilities residing in a nursing facility who shall be assessed using the PAS instrument prescribed in R9-28-303. An individual with developmental disabilities less than 6 months of age, shall be assessed using the PAS instrument described in R9-28-304, and then referred for physician review in accordance with R9-28-302(J).

C. The PAS instrument shall be completed by an Administration assessor who is a registered nurse or a social worker and who has attended a minimum of 24 hours of classroom training for each type of preadmission screening (for EPD individuals and individuals with developmental disabilities). In addition, the Administration shall provide intensive oversight and mentoring for the assessor during the assessor's first 30 days of employment, and ongoing oversight for the assessor's subsequent period of employment.
   1. For initial assessments of EPD individuals, the PAS instrument shall be completed by a registered nurse or by a social worker.
   2. For initial assessments of individuals with developmental disabilities, the PAS instrument shall be completed by a registered nurse or by a social worker.
   3. For initial assessments on hospitalized individuals, the PAS instrument shall be completed by a registered nurse or a team of a registered nurse and social worker.
   4. For initial assessments and reassessments of individuals who use a ventilator, the PAS instrument shall be completed by a team composed of a registered nurse and a social worker.

D. Individuals classified as ventilator dependent, as specified in Section 1902 (e)(9) of the Social Security Act, January 1, 1995

(and no future editions), which is incorporated by reference and is on file with the Administration and the Office of the Secretary of State, shall be determined to require care that is provided at a nursing facility or ICF-MR level.

E. Except as provided in subsection (I), an assessor shall conduct the PAS assessment face-to-face with an individual. The assessor shall make reasonable efforts to obtain available medical records. In addition, the assessor may obtain information for the PAS assessment from interviews with the individual, parent, guardian, caregivers, or others familiar with the individual's functional or medical conditions.

F. Except as provided in subsections (L) and (M), the PAS assessment determines an individual's current need for long-term care.

G. Using the information described in subsection (E), and professional judgment based on education, training, and experience, an assessor shall complete the questions on the PAS instrument.

H. After the PAS instrument is completed, a PAS score is calculated. The calculated PAS score is compared to an established threshold score which is based on statistical analyses of the results of pilot studies completed before implementation of the PAS instrument. Except as provided in subsection (I), the threshold score represents the point at which an individual is determined to require the level of care that is provided at a nursing facility or ICF-MR. The scoring methodology and threshold scores are specified in R9-28-303 and R9-28-304.

I. The Administration shall request that an AHCCCS physician consultant review an individual's file if:

1. An EPD individual's PAS score is less than the threshold specified in R9-28-303, but is not less than 56;
2. The PAS score of an individual with developmental disabilities is less than the threshold specified in R9-28-304, but is not less than 38;
3. Notwithstanding the fact that an individual scores below the threshold, the Administration determines in the course of the preadmission screening that it has reasonable cause to believe that the individual's unique functional abilities or medical condition are such that a physician review is necessary to determine whether the items contained in the scored portions of the PAS instrument would indicate that the individual's condition necessitates the level of care provided in a nursing facility or ICF-MR;
4. An individual has a documented diagnosis as seriously mentally ill as defined in A.R.S. § 36-550, and the Administration determines that the individual has no medical diagnosis that in combination with the serious mental illness could necessitate the level of care provided in a nursing facility or ICF-MR. The review can result in a determination of ineligibility only if the physician determines that despite a score at or above the threshold, the individual does not meet the requirements of A.R.S. § 36-2936; or
5. An individual has a documented diagnosis of Autism, autistic-like behaviors or pervasive developmental disorder, if the individual is not eligible by score.

J. Conducting a review.

1. When conducting a review, the physician shall use the information set out in the PAS instrument to determine whether an individual has a nonpsychiatric medical condition or has a developmental disability that, by itself or in combination with other medical conditions, necessitates the level of care which is provided in a nursing facility or intermediate care facility for the mentally retarded. The physician shall review the PAS instrument and available medical records and use his/her professional judgment to determine whether the individual is at risk of institutionalization. At minimum the physician shall consider the following:
   a. ADL dependence; and delays in development;
   b. Continence;
   c. Orientation;
   d. Behavior;
   e. Medical conditions; stability, prognosis;
   f. Medical nursing treatments including skilled monitoring, medications, therapeutic regimens;
   g. Supervision requirements;
   h. Caregiver skill, training requirements; and
   i. Other factors of significance to the individual case.
2. If the physician is unable to determine eligibility from the PAS instrument and available medical records, the physician may conduct a face-to-face review with the individual or contact others familiar with the individual's needs, including primary care physicians or other caregivers. If the reviewing physician recommends overturning the eligibility determination of the initial assessor, the physician shall state the reasons for that decision in the comments section of the instrument.

K. For initial assessments of individuals who are in a hospital or an intensive rehabilitation facility:

1. If the individual's discharge is planned to occur within 7 days, a PAS assessment shall be performed and medical eligibility determined; or
2. If the individual's discharge is not planned to occur within 7 days, a PAS assessment shall not be done and the individual shall be denied for ALTCS. Using the age and disability of the individual to determine which is appropriate, the Administration shall:
   a. Determine whether the individual's income is equal to or less than the Supplemental Security Benefit amount in effect and forward the individual's records to the Department of Economic Security for determining AFDC-related acute care eligibility for AHCCCS, or
   b. Evaluate the individual's records for an acute care only determination.

L. Upon request, the Administration shall conduct a PAS assessment to determine whether an individual who has been in a nursing or ICF-MR facility within the 3 months before the month of application, is entitled to receive retroactive benefits for that 3-month period.

M. Upon request, the Administration shall conduct a PAS assessment to determine whether a deceased individual who had been in a nursing facility or ICF-MR during the months covered by the application, would have been eligible to receive ALTCS benefits for those months.

R9-28-303. ~~Reassessment~~ Preadmission Screening for Elderly or Physically Disabled Individuals

~~A. All ALTCS members shall be reassessed to determine continued need for ALTCS services. The criteria for continued qualification for ALTCS services shall be the same as those used for initial preadmission screening.~~

~~B. Reassessment may occur in any of the following forms:~~

~~1. Audit of the preadmission screening results by the Administration;~~
~~2. Periodic reassessment by the Administration;~~
~~3. Inspection of care conducted by the Administration. This applies only to care provided in ICF-MRs and IMDs.~~

~~C. All ALTCS members residing in a nursing facility shall receive at a minimum a quarterly resident assessment.~~

A. The PAS instrument for EPD individuals includes 4 major categories: intake information, functional assessment, emotional and cognitive functioning, and medical assessment.
   1. The intake information category solicits information on an individual's demographic background. No components of the intake information category are included in the calculated PAS score.
   2. The functional assessment category solicits information on an individual's:
      a. Need for assistance with activities of daily living, including bathing, dressing, grooming, eating, mobility, transferring, and toileting in the residential environment or other routine setting;
      b. Communication and sensory skills, including hearing, expressive communication, and vision; and
      c. Continence, including bowel and bladder functioning. A history of transitory incontinence caused by an acute or temporary condition or illness shall not be considered for rating.
   3. The emotional and cognitive functioning category solicits information on an individual's:
      a. Orientation to person, place, and time; and
      b. Behavior, including wandering, self-injurious behavior, aggression, suicidal behavior, and disruptive behavior. Some questions in the behavior section refer to intervention and to medical attention. For the purposes of this subsection, medical attention means an examination by a physician, primary care provider, or both, and treatment if necessary.
   4. The medical assessment category solicits information on an individual's:
      a. Medical conditions and the medical condition's impact on the individual's ability to perform activities of daily living independently or whether the conditions require medical or nursing treatments;
      b. Medications, treatments, and allergies;
      c. Specific services and treatments that the individual receives or needs and the frequency of those services and treatments; and
      d. A description of the individual's physical characteristics, hospital history, and ventilator dependency.

B. The PAS instrument for EPD individuals, October, 1992, (and no future amendments or editions), is incorporated by reference and is on file with the Administration and the Office of the Secretary of State. When the PAS instrument is completed, the answers selected by the assessor are used to calculate 3 scores: a functional score, a medical score, and a total score.
   1. Functional score.
      a. The functional score is based on answers to scored questions in the functional assessment and emotional and cognitive functioning categories. Each answer is assigned a number of points. For each scored question, the number of assigned points is multiplied by a weighted numerical value, resulting in a weighted score for each question. The weighted numerical values are based on statistical analyses of pilot study results and reflect the importance of information on the PAS instrument in predicting whether an individual meets the criteria of A.R.S. § 36-2936.
      b. For EPD individuals, some questions in categories noted below are scored, as indicated in subsection (C), under the Functional Assessment matrices:
         i Sensory skills;
         ii. Medical conditions; and
         iii. Medical services and treatments.
      c. For EPD individuals, all questions in categories noted below are scored, as indicated in subsection (C), under the Functional Assessment matrices:
         i. Activities of daily living;
         ii. Continence;
         iii. Orientation; and
         iv. Behavior.
      d. The sum of the weighted scores equals the functional score. The weighted score per question can range from 0 to 15. The maximum functional score attainable by an individual is 141. There is no minimum functional score that needs to be attained except as prescribed in subsections (B)(3)(c) and (B)(3)(d).
   2. Medical score.
      a. The EPD population is divided into 2 groups for purposes of calculating the medical score. The primary distinction between the 2 groups is differences in medical needs.
         i. Group 1 includes individuals diagnosed with paralysis, head trauma, multiple sclerosis, amyotrophic lateral sclerosis, or Parkinson's disease that either impacts the individual's ability to perform activities of daily living independently or requires nursing services or treatments.
         ii. Group 2 includes individuals diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome that either impacts the individual's ability to perform activities of daily living independently or requires nursing services and treatments. If an individual does not meet 1 of the criteria for Group 2, the individual is considered to be in Group 1.
      b. Scoring methodology: Group 1 individuals.
         i. The medical score is based on information obtained from the medical conditions and the services and treatments sections of the PAS instrument.
         ii. Each response to a scored item in the medical assessment category is assigned a certain number of points, ranging from 0 to 4 points per item.
         iii. The sum of the points equals the medical score, with a maximum score of 63. There is no minimum medical score that needs to be attained, except as prescribed in subsection (B)(3)(c).
      c. Scoring Methodology: Group 2 individuals.
         i. The medical score is based on information obtained from the services and treatments section of the PAS instrument.
         ii. Each response to a scored item in the medical assessment category is assigned a number of points, ranging from 0 to 16 points per item.
         iii. The sum of the points equals the medical score, with a maximum score of 42. There is no minimum medical score that needs to be attained, except as prescribed in subsection (B)(3)(d).
   3. Total score.
      a. The sum of an individual's functional and medical scores equals the total score.
      b. The total score is compared to an established threshold score. For all EPD individuals, regardless of whether the individual is in Group 1 or in Group 2, the threshold score is 60. Thus, an individual with a total score equal to or greater than 60 is deemed to

require care that is provided at the nursing facility or ICF-MR level.

c. If an individual is in Group 1 and has a total score less than 60, a functional score equal to or greater than 30 and a medical score equal to or greater than 13, the individual is deemed to require care that is provided at the nursing facility or ICF-MR level.

d. If an individual is in Group 2 and has a total score less than 60:

i. A functional score equal to or greater than 30 and a weighted score from the orientation section equal to or greater than 5, the individual is deemed to require care that is provided at the nursing facility or ICF-MR level; or

ii. A functional score equal to or greater than 30 and the individual is assigned at least 2 points for any 1 question in the behavior section, the individual is deemed to require care that is provided at the nursing facility or ICF-MR level.

C. The following tables represent the number of points available and the weight for each scored question.

Functional Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score per Question (P)x(W)
Activities of Daily Living Section			
Bathing, Dressing, Grooming, Mobility, Toileting	0-5	3.00	0-15
Eating	0-6	2.50	0-15
Transfer	0-4	3.75	0-15
Continence Section			
Bowel	0-2	0	0
	3	.167	.5
Bladder	0-4	0.50	0-2
Sensory Section			
	0-1	0	0
Vision	2	1.75	3.5
	3	1.167	3.5
Orientation Section			
Person, Place, Time	0-3	1.00	0-3

Functional Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score per Question (P)x(W)
Emotional/Cognitive Behavior Section			
Aggression, Self-injurious, Suicidal, Wandering	0-3	1.00	0-3
Disruptive	0-3	3.00	0-9

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal or no impairment and, conversely, the highest value indicates severe impairment.

Medical Assessment Group 1	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P)x(W)
Medical Conditions Section			
Paralysis/Sclerosis	0-1	3.00	0 - 3
Alzheimer's/OBS/ Dementia	0-1	3.50	0 - 3.5
Services and Treatments Section			
Physical Therapy, Occupational Therapy, Speech Therapy	0-1	0.50	0 - 5
Suctioning, Oxygen, Small Volume Nebulizer, Tracheostomy Care, Postural Drainage, Respiratory Therapy	0-1	1.50	0 or 1.5
Drug Regulation	0-1	2.00	0 or 2
Decubitus Care, Wound Care, Ostomy Care, Feedings-Tube and/or Parenteral, Catheter Care, Other Ostomy Care, Dialysis, Fluid Intake/Output	0-1	3.00	0 or 3
Teaching/Training Program, Bowel/ Bladder Program, Range of Motion, Other Rehabilitative Nursing, Restraints	0-1	4.00	0 or 4

Medical Assessment Group 2	# of Points Available per Question (P)	Weight (W)	Range of Possible Weighted Score Per Question[1]
Drug Regulation	0-1	2.00	0 or 2
Teaching/Training Program, Bowel/ Bladder Program, Range of Motion, Other Rehabilitative Nursing	0-1	6.00	0 or 6
Restraints (Physical/Chemical)	0-1	16.00	0 or 16

[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

R9-28-304. Preadmission Screening for Individuals with Developmental Disabilities

A. The Administration shall conduct preadmission screening of individuals with developmental disabilities using 1 of 4 PAS instruments specifically designed to assess individuals in the following age groups: individuals 12 years of age and older; children 6 to 11 years of age; children 3 to 5 years of age; and children less than 3 years of age.

B. The PAS instruments for individuals with developmental disabilities include 3 major categories: intake information, functional assessment, and medical assessment.

1. The intake information category solicits information on an individual's demographic background. No components of the intake information category are scored.
2. The functional assessment category differs by age group, as indicated in subsections (B)(2)(a) through (B)(2)(e) below:
   a. For individuals 12 years of age and older, the functional assessment category solicits information on an individual's:
      i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating/drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
      ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with events and actions, and remembering instructions and demonstrations; and
      iii. Behavior, including aggression, verbal or physical threatening behavior, self-injurious behavior, and resistive/rebellious behavior.
   b. For individuals 6 through 11 years of age, the functional assessment category solicits information on an individual's:
      i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
      ii. Communication, including expressive verbal communication and clarity of communication; and
      iii. Behavior, including aggression, verbal or physical threatening behavior, self-injurious behavior, running or wandering away, and disruptive behavior.
   c. For individuals 3 through 5 years of age, the functional assessment category solicits information on an individual's:
      i. Status with respect to a series of developmental milestones, including 50 factors that measure an individual's degree of functional growth;
      ii. Need for assistance with independent living skills, including toileting and dressing, and the individual's orientation to familiar settings;
      iii. Communication, including clarity of communication; and
      iv. Behavior, including aggression, verbal or physical threatening behavior, and self-injurious behavior.
   d. For individuals 6 months of age and up to 3 years of age, the functional assessment category solicits information on the individual's degree of functional growth using age specific factors.
   e. For individuals less than 6 months of age, a functional assessment is not completed.
3. Function assessment scoring.
   a. For individuals 12 years of age and older, all questions in the behavior section are scored, and some questions in the independent living skills, communication skills, and cognitive abilities sections are scored, as indicated in subsection (D), under the Functional Assessment matrix.
   b. For individuals 6 through 11 years of age, all questions in the communication section are scored, and some questions in the independent living skills and behavior sections are scored, as indicated in subsection (D), under the Functional Assessment matrix.
   c. For individuals 3 through 5 years of age, all questions in the developmental milestones and behavior section are scored, and some questions in the independent living skills are scored, as indicated in subsection (D), under the Functional Assessment matrix.
   d. For individuals 6 months of age up to 3 years of age, all questions regarding specific factors measuring the degree of functional growth are scored, as indicated in subsection (D), under the Functional Assessment matrix.
4. The medical assessment category solicits information on an individual's:
   a. Medical conditions;
   b. Specific services and treatments the individual receives or needs and the frequency of those services and treatments;
   c. Current medications and treatments, medical stability, sensory functioning and physical measurements; and
   d. Current placement, ventilator dependency and DD status of the individual, as determined by the Department of Economic Security.
5. Medical assessment scoring.
   a. For individuals 12 years of age and older, some questions in the medical conditions section are scored, as indicated in subsection (D), under the Medical Assessment matrix.
   b. For individuals 6 years through 11 years of age, some questions in the medical conditions section are scored, as indicated in subsection (D), under the Medical Assessment matrix.
   c. For individuals 3 years of age up to 6 years of age, some questions in the medical conditions and medical stability sections are scored, as indicated in subsection (D), under the Medical Assessment matrix.
   d. For individuals 6 months of age up to 3 years of age, some questions in the medical conditions, services and treatments, and medical stability sections are

scored, as indicated in subsection (D), under the Medical Assessment matrix.

e. For individuals less than 6 months of age, a medical assessment is completed; however, no questions are scored. These individuals are referred for physician review.

C. The PAS instruments for individuals with developmental disabilities, August, 1995, (and no future editions or amendments), are incorporated by reference and are on file with the Administration and the Office of the Secretary of State. When the PAS instrument is completed, the answers selected by the assessor are used to calculate 3 scores: a functional score, a medical score and a total score.

1. Functional score.

a. The functional score is based on answers to scored questions in the functional assessment category. Each answer is assigned a number of points. For each scored question, the number of points is multiplied by a weighted numerical value resulting in a weighted score for each question. The weighted numerical values are based on statistical analyses of the results of pilot studies completed before implementation of the PAS instrument and reflect the importance of information on that instrument in predicting whether an individual meets the criteria of A.R.S. § 36-2936.

b. The sum of the weighted scores equals the functional score. The range of weighted score per question and maximum functional score for each age group is presented below:

AGE GROUP	RANGE FOR WEIGHTED SCORE PER QUESTION	MAXIMUM FUNCTIONAL SCORE ATTAINABLE
12+	0 - 11.2	124.1
6-11	0 - 24.0	112.5
3-5	0 - 15.6	78.2
0-2	0 - 1.4	70.0

c. There is no minimum functional score that needs to be attained.

2. Medical score.

a. The medical score is based on information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an individual is presented below:

AGE GROUP	RANGE OF POINTS PER ITEM	MAXIMUM MEDICAL SCORE ATTAINABLE
12+	0 - 20.6	21.4
6-11	0 - 2.5	5.0
3-5	0 - 14.8	23.0
0-2	0 - 7.0	44.3

b. There is no minimum medical score that needs to be attained.

3. Total score.

a. The sum of an individual's functional and medical scores equals the total score.

b. The total score is compared to an established threshold score. For all individuals with developmental disabilities, the threshold score is 40. Thus, an individual with a total score equal to or greater than 40 is deemed to require care that is provided at the nursing facility or ICF-MR level.

D. The following tables represent the number of points available and the weight for each scored question.

AGE GROUP 12 AND OLDER Functional Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Independent Living Skills Section			
Hand Use, Food Preparation	0-3	3.50	0-10.5
Ambulation, Toileting, Eating, Dressing, Personal Hygiene	0-4	2.80	0-11.2
Communicative Skills and Cognitive Abilities Section			
Associating Time, Remembering Instructions	0-3	0.50	0 - 1.5
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	2.80	0-11.2
Resistive	0-3	3.50	0-10.5

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.

AGE GROUP 12 AND OLDER Medical Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	0.40	0-.4
Moderate, Severe, Profound Mental Retardation	0-1	20.60	0-20.6

[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

AGE GROUP 6-11 Functional Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Independent Living Skills Section			
Climbing Stairs, Wheelchair Mobility, Bladder Control	0-3	1.875	0-5.625
Ambulation, Dressing, Bathing, Toileting	0-4	1.50	0-6
Crawling/Standing	0-5	1.25	0-6.25
Rolling/Sitting	0-8	0.833	0-6.66
Communication Section			
Clarity	0-4	1.50	0-6
Expressive Communication	0-5	1.25	0-6.25
Behavior Section			
Wandering	0-4	6.00	0-24
Disruptive	0-3	7.50	0-22.5

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.

AGE GROUP 6 - 11 Medical Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	2.50	0-2.5

[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

AGE GROUP 3-5	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Functional Assessment			
Developmental Milestones Section			
Factors Measuring an Individual's Degree of Functional Growth	0-1	0.70	0-.7
Independent Living Skills Section			
Toileting, Dressing	0-4	3.90	0-15.6
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	1.00	0-4

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.

AGE GROUP 3 - 5 Medical Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Medical Conditions Section			
Moderate, Severe, Profound Mental Retardation	0-1	14.80	0-14.8
Medical Stability Section			
Direct Caregiver Required, Special Diet	0-1	4.10	0-4.1

[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

AGE GROUP 0-2 Functional Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Developmental Milestones Section			
Factors Measuring an Individual's Degree of Functional Growth	0-1	1.40	0-1.4

AGE GROUP 0-2 Medical Assessment	# of Points Available Per Question[2]	Weight	Range of Possible Weighted Score Per Question (P) x (W)
Services and Treatments Section			
Non-Bladder/Bowel Ostomy, Tube Feeding, Oxygen	0-1	6.10	0-6.1
Medical Conditions Section			
Any Mental Retardation, Epilepsy, Cerebral Palsy	0-1	7.00	0-7
Medical Stability Section			
Trained Direct Caregiver, Special Diet or a Minimum of 2 Hospitalizations	0-1	5.00	0-5

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.

[2]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

R9-28-305. Reassessments

A. An Administration assessor shall reassess each ALTCS member to determine continued need for ALTCS services. The assessor shall base the determination of continued qualification for ALTCS services on the same criteria used for the initial preadmission screening as prescribed in R9-28-302, R9-28-303 and R9-28-304.

B. One or more of the individuals described in R9-28-302(C) shall conduct each reassessment and may refer the assessment for physician review.

C. Reassessment by the Administration shall occur as follows:

1. Annually, except in the following circumstances:
   a. EPD individuals 80 years of age and older who have been ALTCS eligible for 2 consecutive years shall be reassessed every other year;
   b. EPD individuals diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome who have been ALTCS eligible for 2 consecutive years shall be reassessed every other year;
   c. EPD individuals who have been eligible for 2 or more consecutive years and have had a SNF-2 level of care on their last 2 PAS assessments shall be reassessed every other year;
   d. EPD individuals who have been eligible for 3 or more consecutive years and have been continuously institutionalized for 3 or more years shall be reassessed every other year;
   e. DD individuals with severe or profound mental retardation who have been eligible for 2 or more consecutive years shall be reassessed every other year; and
   f. The Administration identifies other EPD and DD population groups within the ALTCS program for which a reassessment period greater than 1 year is appropriate.
2. In connection with routine audit of the preadmission screening by the Administration in which errors affecting eligibility are discovered.
3. In connection with an audit of the preadmission screening requested by a nursing facility, program contractor, case manager, or other party where the Administration has determined that continued eligibility is uncertain due to substantial evidence of a change in the member's circumstances or error in the preadmission screening; and
4. At the request of the Administration's physician consultant.